SUPREME COURT OF THE UNITED STATES

No. 14-181

Title:	Alfred Gobeille, in His Official Capacity as Chair of the Vermont Green Mountain Care Board, Petitioner v. Liberty Mutual Insurance Company
Docketed:	August 15, 2014
Lower Ct:	United States Court of Appeals for the Second Circuit
Case Nos.:	(12-4881)
Decision Date:	February 4, 2014
Rehearing Denied:	May 16, 2014

Questions Presented

—Date—	------Proceedings and Orders----------
Aug 13 2014	Petition for a writ of certiorari filed. (Response due September 15, 2014)
Sep 10 2014	Order extending time to file response to petition to and including October 15, 2014.
Sep 15 2014	Brief amici curiae of New York, et al. filed.
Oct 10 2014	Order further extending time to file response to petition to and including November 6, 2014.
Nov 6 2014	Brief of respondent Liberty Mutual Insurance Company in opposition filed.
Nov 21 2014	Reply of petitioner Alfred Gobeille, in His Official Capacity as Chair of the Vermont Green Mountain Care Board filed. (Distributed)
Nov 25 2014	DISTRIBUTED for Conference of December 12, 2014.
Dec 15 2014	The Solicitor General is invited to file a brief in this case expressing the views of the United States.
May 19 2015	Brief amicus curiae of United States filed.
Jun 1 2015	Supplemental brief of petitioner Alfred Gobeille, in His Official Capacity as Chair of the Vermont Green Mountain Care Board filed. (Distributed)
Jun 2 2015	DISTRIBUTED for Conference of June 18, 2015.
Jun 3 2015	Supplemental brief of respondent Liberty Mutual Insurance Company filed. (Distributed)
Jun 22 2015	DISTRIBUTED for Conference of June 25, 2015.
Jun 29 2015	Petition GRANTED.
Jul 9 2015	Consent to the filing of amicus curiae briefs in support of either party or of neither party received from counsel for the petitioner.
Jul 10 2015	Consent to the filing of amicus curiae briefs, in support of either party or of neither party, received from counsel for respondent.
Jul 16 2015	The time to file the joint appendix and petitioner's brief on the merits is extended to and including August 28, 2015.
Jul 16 2015	The time to file respondent's brief on the merits is extended to and including October 13, 2015.

Aug 28 2015	Brief of petitioner Alfred Gobeille, in His Official Capacity as Chair of the Vermont Green Mountain Care Board filed.
Aug 28 2015	Joint appendix filed. (Statement of costs filed)
Sep 1 2015	Brief amicus curiae of Professor Edward A. Zelinsky in support of neither party filed.
Sep 2 2015	Brief amici curiae of Association of American Physicians and Surgeons, Inc., et al. in support of neither party filed.
Sep 3 2015	Brief amici curiae of National Governors Association, et al. filed.
Sep 3 2015	Brief amicus curiae of New Hampshire filed.
Sep 4 2015	Brief amicus curiae of the United States filed.
Sep 4 2015	Brief amici curiae of American Hospital Association and Association of American Medical Colleges filed.
Sep 4 2015	Brief amici curiae of New York, et al. filed.
Sep 4 2015	Brief amicus curiae of Connecticut Health Insurance Exchange D/B/A Access Health CT filed.
Sep 4 2015	Brief amici curiae of Harvard Law School Center for Health Law and Policy Innovation, et al. filed.
Sep 4 2015	Brief amici curiae of AARP, Families USA, and U.S. Public Interest Research Group filed.
Sep 4 2015	Brief amici curiae of National Association of Health Data Organizations (NAHDO), et al. filed.
Sep 4 2015	Brief amici curiae of American Medical Association and Vermont Medical Society filed.
Sep 25 2015	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
Oct 9 2015	SET FOR ARGUMENT on Wednesday, December 2, 2015
Oct 13 2015	Brief of respondent Liberty Mutual Insurance Company filed.
Oct 19 2015	Record requested from the U.S.C.A. 2nd Circuit.
Oct 20 2015	Brief amici curiae of American Benefits Council, et al. filed.
Oct 20 2015	Brief amicus curiae of Blue Cross and Blue Shield Association filed.
Oct 20 2015	Brief amicus curiae of National Coordinating Committee for Multiemployer Plans filed.
Oct 20 2015	Brief amicus curiae of New England Legal Foundation filed.
Oct 21 2015	Record received from the U.S.C.A. 2nd Circuit is electronic.
Oct 21 2015	Record from the U.S.D.C. District of Vermont is electronic and located on PACER.
Oct 27 2015	CIRCULATED
Nov 9 2015	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
Nov 12 2015	Reply of petitioner Alfred Gobeille, in His Official Capacity as Chair of the Vermont Green Mountain Care Board filed. (Distributed)
Dec 2 2015	Argued. For petitioner: Bridget C. Asay, Vermont Solicitor General, Montpelier, Vt.; and John F. Bash, Assistant to the Solicitor General, Department of Justice, Washington, D. C. (for United States, as amicus curiae.) For respondent: Seth P. Waxman, Washington, D. C.
Mar 1 2016	Adjudged to be AFFIRMED. Kennedy, J., delivered the opinion of the Court, in which Roberts, C. J., and Thomas, Breyer, Alito, and Kagan, JJ., joined. Thomas, J., and Breyer, J., filed concurring opinions. Ginsburg, J., filed a dissenting opinion, in which Sotomayor, J., joined.
Apr 4 2016	JUDGMENT ISSUED

No. 14-181

In The
Supreme Court of the United States

ALFRED J. GOBEILLE, IN HIS OFFICIAL CAPACITY AS CHAIR OF THE VERMONT GREEN MOUNTAIN CARE BOARD,

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Vermont, like many other States, requires health care providers and health care payers to provide claims data and related information to the State's health care database. The law applies to all public and private entities that pay for health care services, including insurers, government programs, and third-party administrators. The State relies on the database to inform health care policy. The question presented is:

Did the Second Circuit – in a 2-1 panel decision that disregarded the considered opinion advanced by the United States as amicus – err in holding that ERISA preempts Vermont's health care database law as applied to the third-party administrator for a self-funded ERISA plan?

PARTIES TO THE PROCEEDING

Petitioner Alfred J. Gobeille, in his official capacity as Chair of the Green Mountain Care Board, has been substituted for Commissioner Susan L. Donegan, who was the appellee in the court of appeals. *See* Supreme Court R. 35.3. Chair Gobeille has been substituted because the Vermont Legislature shifted responsibility for the unified health care database to the Green Mountain Care Board, effective June 7, 2013. 2013 Vt. Acts & Resolves, No. 79, § 40. The original defendant in the district court was Commissioner Stephen W. Kimbell. Commissioner Donegan was substituted as a party when she replaced Commissioner Kimbell in office.

The respondent, Liberty Mutual Insurance Company, was the appellant in the court of appeals and the plaintiff in the district court.

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Alfred J. Gobeille, as Chair of the Vermont Green Mountain Care Board, respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Second Circuit in this case.

INTRODUCTION

Health care policy is a pressing concern at every level of government. Many States, including Vermont, rely on health care databases for accurate, complete information to support, inform, and test health care policies. The Second Circuit's unjustified expansion of ERISA preemption in this case threatens these important tools adopted by sixteen States. And the panel majority's reasoning – that state recordkeeping or information-gathering requirements of any kind intrude on core ERISA concerns – applies far more broadly, creating uncertainty about a wide range of health and safety regulations.

In our federal system, the "regulation of health and safety matters is primarily, and historically, a matter of local concern." *Hillsborough Cnty. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 719 (1985). This Court cautioned nearly twenty years ago that ERISA was not intended to displace the States' authority over "general health care regulation." *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995). The Second Circuit disregarded this Court's direction. It

adopted an expansive view of ERISA preemption that conflicts with this Court's holdings and substantially undermines the States' historic police powers. The States' interests in pursuing their chosen policies, and the harm to those interests caused by the lower court's ruling, strongly support immediate review by this Court.

OPINIONS BELOW

The opinion of the court of appeals (App. 1-47) is reported at 746 F.3d 497. The memorandum opinion and order of the district court (App. 48-80) is not reported, but is available at 2012 WL 5471225.

JURISDICTION

The judgment of the court of appeals was entered on February 4, 2014. Petitioner filed a timely petition for rehearing en banc on February 18, 2014. The petition for rehearing was denied on May 16, 2014. App. 81-82. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the U.S. Constitution provides:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

U.S. Const. art. VI, cl. 2.

The "other laws" provision of the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1144, is set forth at App. 83-90.

Vermont's health care database statute, Vt. Stat. Ann. tit. 18, § 9410, is set forth at App. 92-99. The Appendix also includes the prior version of the statute, before a 2013 amendment that shifted responsibility for the database to the Green Mountain Care Board. App. 99-106.

The Regulation that governs the database, Regulation H-2008-01, is set forth at App. 107-41. The appendices to the Regulation (which include charts, tables, and forms) are available online at http://gmcboard.vermont.gov/sites/gmcboard/files/REG_H-2008-01.pdf.

STATEMENT

1. Vermont's "unified health care database" collects critical information that informs the State's health care policy, including its policy "to ensure that all residents have access to quality health services at costs that are affordable." Vt. Stat. Ann. tit. 18, § 9401(a) (App. 91); *id.* § 9410(a)(1) (App. 92). The database contains information supplied by health care providers and health care "payers" – that is, government agencies, insurers, and similar entities that pay for health care services. *Id.* § 9410(c), (h), (j) (App. 94-99). The purposes of the database include:

> (A) Determining the capacity and distribution of existing resources.
>
> (B) Identifying health care needs and informing health care policy.
>
> (C) Evaluating the effectiveness of intervention programs on improving patient outcomes.
>
> (D) Comparing costs between various treatment settings and approaches.
>
> (E) Providing information to consumers and purchasers of health care.
>
> (F) Improving the quality and affordability of patient health care and health care coverage.

Id. § 9410(a)(1)(A)-(F) (App. 92).

Vermont's Green Mountain Care Board administers the database, known as VHCURES.[1] The Board was created in 2011 to, among other things, improve the health of Vermont residents; reduce the growth of health care costs while protecting access to health care and quality of care; and simplify health care financing and delivery. Vt. Stat. Ann. tit. 18, § 9372.

The Board has a broad array of regulatory and innovative responsibilities, including administering Vermont's health care expenditure analysis, *id.* § 9375a; approving hospital budgets, *id.* § 9375(7); overseeing payment reform pilot projects, *id.* §§ 9375(1), 9377; approving health insurance rates, *id.* § 9375(6); reviewing applications for certificates of need for new health care projects, *id.* § 9375(b)(8); and evaluating the quality of Vermont's health care system, *id.* § 9375(10).

The Board maintains and uses the health care database to "carry out [its] duties." *Id.* § 9410 (App. 92). For example, it uses the data to inform its review of health insurance rates and hospital budgets. Vt. Stat. Ann. tit. 8, § 4062; Vt. Stat. Ann. tit. 18, §§ 9375(b)(6)-(7), 9456. The Board also relies on the data for oversight and evaluation of health care

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[1] The Vermont Legislature shifted responsibility for the database from the Department of Financial Regulation to the Green Mountain Care Board during the litigation. 2013 Vt. Acts & Resolves, No. 79, § 40.

payment and delivery system reforms. *Id.* §§ 9375(b)(1), 9377.

The database statute requires "[h]ealth insurers, health care providers, health care facilities, and governmental agencies" to "file reports, data, schedules, statistics, or other information determined by the Board to be necessary to carry out the purposes" of the law. *Id.* § 9410(c) (App. 94). For this purpose, "health insurer" includes "any third party administrator, any pharmacy benefit manager, any entity conducting administrative services for business, and any other similar entity with claims data, eligibility data, provider files, and other information relating to health care provided to Vermont resident[s]." *Id.* § 9410(j)(1)(B) (App. 98). The implementing rule notes that the term "may also include, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities." Regulation H-2008-01, § 3(X) (App. 112-13). Only insurers with 200 or more covered members living in Vermont (or receiving covered services in Vermont) must provide information to the database. *Id.* § 3(Ab) (App. 113).

State Regulation H-2008-01 (App. 107-41) supplies the details of database administration.[2] The rule

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[2] Reg. H-2008-01, reprinted at App. 107-41, was promulgated by the Vermont Department of Financial Regulation, which previously administered the database. The regulation remains in effect.

sets forth "requirements for the submission of health care claims data, member eligibility data, and other information relating to health care provided to Vermont residents or by Vermont health care providers." *Id.* § 1 (App. 107). The rule also provides "conditions for the use and dissemination of such claims data." *Id.*

Information is collected and maintained so as to protect personal privacy. The statute requires compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), *see* Vt. Stat. Ann. tit. 18, § 9410(h)(2) (App. 96), and mandates that confidential information be "filed in a manner that does not disclose the identity of the protected person." *Id.* § 9410(e) (App. 94-95). And it prohibits public disclosure of "direct personal identifiers," including names, addresses, and Social Security numbers. *Id.* § 9410(h)(3)(D) (App. 97-98). The statute also calls for a confidentiality code and penalizes violation of confidentiality requirements. *Id.* § 9410(f), (g) (App. 95). The regulation provides standards for code and encryption requirements, Reg. H-2008-01, § 5(A)(5) (App. 119-21), and restricts submission of "direct personal identifiers," *id.* § 7(A)(5) (App. 128-29).

As permitted by HIPAA and these confidentiality requirements, the Board may provide access to data "as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in Vermont." Vt. Stat. Ann. tit. 18, § 9410(h)(3)(B) (App. 97). The regulation

carefully delineates data sets that are publicly available, data that may not be disclosed, and data that is available to researchers that agree to protect confidentiality and control access. Reg. H-2008-01, § 8 (App. 130-39).

2. Respondent Liberty Mutual is an insurance company based in Massachusetts. Liberty Mutual provides health care for about 80,000 employees, retirees, and their families through a self-funded plan governed by ERISA. Liberty Mutual is the "named fiduciary" and "plan administrator" for ERISA purposes. App. 7-8, 50.

Liberty Mutual has employees and does business in Vermont. Its plan provides benefits for 137 Vermont residents. App. 7, 50. Because of its small number of Vermont participants, Liberty Mutual itself is not required to provide information for Vermont's database. App. 8, 58. Liberty Mutual, however, contracts with a third-party administrator, Blue Cross Blue Shield of Massachusetts, to administer the plan. App. 8, 50-51. Blue Cross "processes medical claims . . . , receives participants' confidential medical records and generates claims data." App. 50-51. Blue Cross provides or administers benefits for about 7,000 Vermonters, including Liberty Mutual's plan participants, Ct. App. J.A. 288, so Blue Cross is obligated to provide its data to Vermont. App. 8. It provides that information for other self-funded ERISA plans. App. 72-73 n.5.

Vermont's Department of Financial Regulation (previously responsible for the database) subpoenaed Blue Cross in August 2011, seeking claims data and other required information for the database. App. 8-9. Liberty Mutual directed Blue Cross not to report information for its beneficiaries. Blue Cross complied with the subpoena in all other respects, but did not submit data for Vermont participants in Liberty Mutual's plan. App. 9, 56.

3. Liberty Mutual then filed this lawsuit, claiming that ERISA preempts any requirement that its third-party administrator provide information for Vermont's health care database. App. 9, 48, 56. The State moved to dismiss for lack of standing and failure to state a claim; Liberty Mutual moved for summary judgment. App. 9, 49. With the agreement of the parties, the district court treated the motions as cross-motions for summary judgment. *Id.* In a written decision, the district court rejected Liberty Mutual's preemption claim and granted judgment to the State. App. 48-80.

The district court first held that Liberty Mutual had standing. App. 61. Although Liberty Mutual had no independent obligation to provide information to the database, the regulation required Blue Cross to provide information for Liberty Mutual's plan. App. 58. The court reasoned that Liberty Mutual was "subject to regulation" through the State's regulation of Blue Cross, the third-party administrator. App. 59.

Turning to Liberty Mutual's claim of preemption, the district court noted that a "statute that operates in the health care field will receive the benefit of the presumption against preemption, even if it does not directly regulate health care providers or services." App. 65. The court then held that Liberty Mutual did not "overcome the presumption against preemption." App. 64-66, 79.

First, the court held that the database statute does not have a "reference" to ERISA plans. App. 69. "Vermont's statute and regulation do not act immediately and exclusively upon ERISA plans, nor is the existence of ERISA plans essential to their operation." App. 69. As the court explained, the law requires numerous entities, including insurers and providers, to supply information to the database. *Id.*

Second, the court concluded that the database statute does not have an impermissible "connection with" an ERISA plan. App. 70-78. After surveying this Court's decisions and relevant circuit precedent, the district court emphasized that Vermont's law: (1) did not "attempt to control, supersede or interfere with the operation of an ERISA plan"; (2) "has no effect whatsoever on the core relationships that ERISA was designed to protect – those between participants, beneficiaries, administrators and employers"; and (3) has "no effect whatsoever on the core ERISA functions – such as processing claims or disbursing benefits." App. 79.

The court recognized that even a generally applicable law might be preempted if it "creates an economic effect so acute as to dictate certain administrative choices." App. 72. Here, however, Liberty Mutual had no reporting obligations at all, and there was "no evidence" that its third-party administrator, Blue Cross, was "laboring under any sort of burden" in complying with the law. App. 72 n.5. Blue Cross provided the information for other ERISA plans. App. 73 n.5. Liberty Mutual did "not submit[ ] any information about any actual burden suffered by itself or [Blue Cross] in producing this information." *Id.*

4. On appeal, the Second Circuit reversed in a split decision. App. 1-47. While agreeing with the district court that Vermont's statute and regulation "lack 'reference to' an ERISA plan," App. 23 n.9, the majority held that Vermont's law has an impermissible "connection with" ERISA plans. App. 23. In a footnote, the majority concluded that Vermont's health care database law was not an exercise of "the states' historic police powers" and declined to apply the presumption against preemption. App. 18 n.8.

The court viewed "reporting" as a core ERISA concern that is undermined by any state requirement for "plan record-keeping, and filing with a third party." App. 23-24. It emphasized that Vermont's database "is called the 'Vermont Healthcare Claims Uniform *Reporting* and Evaluation System.'" App. 24. The majority viewed as irrelevant the fact that

Vermont's database seeks information unrelated to ERISA's reporting requirements. App. 24 n.11.

The court concluded that, consistent with ERISA, only a "slight reporting burden" would be permissible. App. 24. The majority saw Vermont's "scheme" as "obviously intolerable," describing the claims data reporting requirements as "burdensome, time-consuming, and risky." App. 25. Other than merely citing the regulation, however, the court pointed to no evidence of financial costs or other burdens. The court further reasoned that any "burdens and risks must be multiplied" because of unspecified reporting requirements in other states. App. 29. The court described Vermont's detailed confidentiality provisions as "complex but loose" and suggested that the regulation was problematic because it could be changed in the future. App. 27-28.

Based on this reasoning, the majority held Vermont's law preempted. App. 23-29. It reached this conclusion without addressing the United States Department of Labor's support, as amicus curiae, for the district court's decision and Vermont's position.

Judge Straub dissented. App. 30-47. The dissent sharply criticized the majority for failing to apply the presumption against preemption. App. 33-34. Judge Straub also pointed out that the majority's description of Vermont's reporting requirement as "time-consuming and risky" was "pure speculation." App. 46. "There is no evidence to support such a finding." *Id.*

The dissent reasoned that Vermont's health care database is "wholly distinct" from ERISA's reporting requirements and seeks "after-the-fact information which plan administrators . . . already have in their possession." App. 38, 39. "The Vermont statute regulates health care within that state, while imposing a purely clerical burden on ERISA plans." App. 46. The law "does not hinder the national administration of employment benefit plans" or require any "distinction in benefits between Vermont and any other state." App. 44. For the dissent, that "end[ed] the inquiry." *Id.*

5. Vermont filed a timely petition for rehearing en banc, which was denied on May 16, 2014. App. 81-82.

REASONS FOR GRANTING THE WRIT

This Court should grant review to address the Second Circuit's broad and unprecedented expansion of ERISA preemption. The lower court's decision sharply conflicts with this Court's ERISA jurisprudence. It will have a profound impact on health care regulation in sixteen States with programs like the one held preempted here. And because the Second Circuit has introduced uncertainty into an important area of the law, its decision, if left in place, will have a substantial impact on state and federal regulatory interests.

1. The lower court's ruling is not merely an erroneous application of the law. The Second Circuit embraced an expansive view of ERISA preemption that this Court – after many years and countless ERISA cases – firmly rejected in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co*, 514 U.S. 645, 654-56 (1995). Vermont's database statute is a generally applicable law through which the State obtains information from the health care industry to develop policies that support the health and well-being of its citizens. It is not targeted at ERISA plans. It does not regulate the benefits provided, plan governance or finances, or the relationship between the plan and its participants. It is therefore not preempted by ERISA. The Second Circuit held otherwise only by disregarding settled principles – including the scope of the States' historic police powers and the presumption against preemption. The unacceptable and irreconcilable conflict with this Court's precedents warrants immediate review, a conclusion supported by a recent Sixth Circuit decision "disagree[ing]" with the Second Circuit's "literal approach to [ERISA] preemption," *see Self-Ins. Inst. of America, Inc. v. Snyder*, No. 12-2264, 2014 WL 3804355, at *7 (6th Cir. Aug. 4, 2014) [hereinafter "*SIIA*"].

2. The importance of the issue presented further justifies granting the petition. The decision below undermines efforts by at least sixteen States – including all three States in the Second Circuit – to create and use comprehensive health care databases.

The breadth of the lower court's decision also casts a shadow over a wide range of other state regulations. In contrast to this Court's holdings, which recognize that States may permissibly impose administrative costs and burdens on ERISA plans, the Second Circuit has deemed routine recordkeeping and submission of information to be a "core" ERISA concern. App. 23-24. The decision thus provides a basis for challenging state health care regulations, taxes, licensing, and safety rules – all of which typically require recordkeeping and reporting of compliance information.

The lower court's ruling treads on both state and *federal* interests. The United States Department of Labor voluntarily participated as amicus curiae in the court of appeals and supported the district court's decision and Vermont's position. Despite the Department's recognized expertise in ERISA – and its administration of ERISA's reporting requirements – the 2-1 panel decision of the Second Circuit rejected (without any discussion whatsoever) the Department's considered position. The Department's decision to participate as an amicus confirms that this case – and the scope of ERISA preemption generally – is a matter of pressing importance to the federal government as well as the States.

I. The decision below is an unprecedented expansion of ERISA preemption that conflicts with this Court's decisions in *Travelers*, *Dillingham*, and *De Buono*.

This Court has repeatedly disavowed the "expansive and literal" approach to ERISA preemption that the 2-1 panel decision of the Second Circuit adopted in this case. *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 812-14 (1997); *see also Travelers*, 514 U.S. at 654-56. Instead, this Court's decisions establish a framework for evaluating claims of ERISA preemption that focuses on the purposes of ERISA and acknowledges the States' primary role in regulating matters of health and safety. The Second Circuit's decision marks a clear and unacceptable conflict with this Court's precedent.

A. *Travelers* and *De Buono* narrowed ERISA preemption by focusing on Congress's intent and reaffirming the presumption that Congress does not intend to displace state law in areas traditionally regulated by the States.

This Court's decisions in *Travelers* and *De Buono* narrowed and focused the scope of ERISA preemption in three important ways. First, the Court rejected an approach to preemption grounded in "uncritical literalism," instead directing courts to look to "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Travelers*, 514 U.S. at 656. Given the

"frustrating difficulty" of interpreting ERISA's "unhelpful text," *Travelers* and *De Buono* hold that the preemption inquiry must be guided by ERISA's underlying objectives and purposes. *Id.*; *De Buono*, 520 U.S. at 813.

Second, *Travelers* delineated the key areas in which ERISA preempts state law. The "basic thrust of the preemption clause . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Travelers*, 514 U.S. at 657. Accordingly, ERISA "preempt[s] state laws that mandate[ ] employee benefit structures or their administration." *Id.* at 658. Preempted state laws include coverage mandates, anti-subrogation rules, alternative enforcement mechanisms, and laws affecting benefit calculations. *Id.* at 657-58. Later cases reiterated this core concern with state laws that "require[ ] employers to provide certain benefits" or govern the calculation of benefits. *De Buono*, 520 U.S. at 815; *see also Cal. Div. Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 328 (1997).

Third, the Court "unequivocally concluded" that ERISA's preemption clause does not modify the presumption against preemption of state law. *De Buono*, 520 U.S. at 813. The Court explained in *Travelers* that it "never assume[s] lightly that Congress has derogated state regulation." 514 U.S. at 654; *see also Wyeth v. Levine*, 555 U.S. 555, 565 (2009) (describing the presumption against preemption as a "cornerstone" of the Court's preemption jurisprudence). Nothing in

ERISA "indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. at 661. ERISA accordingly does not preempt "'myriad state laws' of general applicability that impose some burdens on the administration of ERISA plans." *De Buono*, 520 U.S. at 815 (quoting *Travelers*, 514 U.S. at 668); *see also Dillingham*, 519 U.S. at 333-34.

These principles have provided direction to the States and to the lower courts for almost 20 years. Claims of ERISA preemption "generated an avalanche of litigation" in the years after ERISA's adoption. *De Buono*, 520 U.S. at 808-09 n.1. *De Buono* was the Court's sixteenth ERISA preemption case and the third case just that term. *See id.* The series of decisions in *Travelers*, *De Buono*, and *Dillingham* cabined ERISA preemption to a reasonable scope, and gave state policymakers necessary guidance on the line between federal and state authority. As explained below, the Second Circuit in this case departed so substantially from this controlling precedent that its decision creates an unacceptable degree of confusion and uncertainty.

B. The lower court departed from these settled principles and adopted a broad interpretation of ERISA preemption that directly conflicts with this Court's holdings.

As the United States argued below, Vermont's law is not preempted because it "does not regulate the

structures or core functions of ERISA plans." U.S. Ct. App. Br. 11. The Second Circuit concluded otherwise only by disregarding this Court's teachings about the scope of ERISA preemption.

1. The Second Circuit engaged in precisely the kind of rigid, literal analysis that this Court disavowed in *Travelers* and *De Buono*. The panel majority's decision was predicated on its view that, because ERISA governs plan reporting, any type of state reporting requirement must intrude on a core ERISA concern. Consistent with that literal approach, the court emphasized that Vermont's law requires Liberty Mutual's third-party administrator to "*report*" claims data for the health care database. App. 23-24. But Vermont's law does not intrude on an area of core ERISA concern merely because it seeks information from the plan administrator. This Court explained in *Dillingham* that "[i]n enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds." 519 U.S. at 326-27 (quotation omitted). It was "*[t]o that end*" that Congress "established extensive reporting, disclosure, and fiduciary duty requirements to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator." *Id.* (emphasis added) (quotation omitted). The Second Circuit's myopic focus on the word "reporting," instead of the purposes of ERISA, conflicts with *Travelers* and *Dillingham*. Recognizing

these principles established by this Court's precedents, the Sixth Circuit in *SIIA* "disagree[d]" with the Second Circuit's "literal approach to preemption," *SIIA*, 2014 WL 3804355, at *7. The *SIIA* court, in line with this Court's rulings, acknowledged ERISA's principal concern with the financial solvency of plans, and held that Congress did not intend ERISA's reporting requirements to "preclude states from enacting laws imposing administrative burdens – of any kind – upon plan administrators and sponsors unrelated to the administration of the plans." *Id.* at *5.

Vermont's health care database – as the United States observed in its filing below – is unrelated to ERISA's core concern with plan administrators' fiduciary responsibilities to beneficiaries. "The focus and purpose of Vermont's data collection . . . are quite different" from ERISA's concerns. U.S. Ct. App. Br. 12. Vermont seeks claims data to improve health care quality, affordability, and effectiveness, Vt. Stat. Ann. tit. 18, § 9410(a) (App. 92), and seeks no information whatsoever about plan funding or governance. By contrast, a plan's annual report to the Secretary of Labor is "principally concerned with the financial soundness of the plan." U.S. Ct. App. Br. 12. The Vermont law does not protect beneficiaries or provide them with information; indeed, the law "does not include disclosure requirements affecting the employer-employee or plan-participant relationship." U.S. Ct. App. Br. 13. Given the sharp disconnect between ERISA's objectives and the purposes of Vermont's law, the dissent below aptly observed that the

"majority's argument misses the nuance of what 'reporting' means in the context of ERISA, and ignores the case law's focus on whether the *administration of benefits to beneficiaries* is impacted." App. 32 (Straub, J., dissenting); *see also SIIA*, 2014 WL 3804355, at *7 (quoting same).

2. The lower court's analysis also contravenes this Court's guidance about the types of state laws preempted by ERISA. Together, *Travelers*, *Dillingham*, and *De Buono* teach that ERISA's central concern is with state laws that dictate the types of benefits provided by plans or the manner in which plans administer those benefits. *Travelers*, 514 U.S. at 657-58; *Dillingham*, 519 U.S. at 328, 333-34; *De Buono*, 520 U.S. at 815. Vermont's health care database does not touch on these areas. The law "does not meaningfully regulate plans' benefit programs or affect plans' administration of benefits." U.S. Ct. App. Br. 14-15.

Instead of recognizing these limits on the scope of ERISA preemption, the Second Circuit panel majority mistakenly focused on the law's supposed administrative burdens. But ERISA does not preempt "'myriad state laws' of general applicability that impose some burdens on the administration of ERISA plans." *De Buono*, 520 U.S. at 815 (quoting *Travelers*, 514 U.S. at 668). Administrative cost or burden is relevant only if the burden is "so acute 'as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers.'" *De Buono*, 520 U.S. at 816 n.16 (quoting *Travelers*, 514 U.S. at

668). As the dissenting opinion concluded, there was "no basis to find that the Vermont statute would cause Liberty Mutual to increase its costs more than a *de minimus* amount . . . much less . . . cause a fiduciary to change a plan in any way." App. 40-41 (Straub, J., dissenting).[3]

In short, the lower court's decision irreconcilably conflicts with both the reasoning and the results reached in this Court's precedents. The Court has

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[3] The majority's description of the supposed burdens is factually unsupported and wrong. As the district court pointed out, Liberty Mutual submitted no evidence of "any actual burden." App. 72-73 n.5. On appeal, Liberty Mutual merely asserted that "all regulations have their costs" and claimed that Vermont's law was "*per se* burdensome." Liberty Mutual Ct. App. Br. 28. The dissent highlighted Liberty Mutual's failure "to provide any details or showing of the alleged burden," and sharply criticized the majority for engaging in "pure speculation" on this point. App. 39, 46 (Straub, J., dissenting). As the dissent noted, Vermont's law "asks for after-the-fact information which plan administrators . . . already have" and "by all accounts [Blue Cross] is happy to provide the data . . . and . . . does so for other clients." App. 39 (Straub, J., dissenting). Moreover, while this case was pending on appeal, the federal Centers for Medicare and Medicaid Services (CMS) agreed to provide its claims data to Vermont's database. *See* Data Use Agreement Between CMS and Green Mountain Care Board (No. 25534), *available at* http://gmcboard.vermont.gov/sites/gmcboard/files/CMS_DUA_%2025534_SIGNED_Attachment_A_ExSum.pdf. That agreement confirms the federal government's confidence in Vermont's program, and undercuts any suggestion that the database provides inadequate confidentiality protections. Protecting personal privacy is critical to this program. There was "no evidence" to support a contrary conclusion. App. 46 (Straub, J., dissenting).

repeatedly upheld state laws that challengers described as imposing costs and burdens on ERISA plans. In *Mackey v. Lanier Collection Agency*, 486 U.S. 825, 831 (1988), the plan administrators complained of "substantial administrative burdens and costs" caused by state-law garnishment proceedings. The Court rejected the preemption claim. *Id.* at 832, 841. In *Dillingham*, the Court upheld a California law regulating apprenticeship programs, even though the law required a plan to either obtain state approval for its program or pay a higher minimum wage to apprentices. 519 U.S. at 319-21, 330-33.

And most relevant here, in *De Buono* the Court held that New York could permissibly tax the gross receipts of a hospital operated by an ERISA plan. 520 U.S. at 814-16. The generally applicable tax was not preempted even though it "increase[d] the cost of providing benefits" and had "some effect" on plan administration. *Id.* at 816. Taxation inevitably requires "particular form[s] of record-keeping"; likewise, taxes are potentially "inconsistent" from state to state. *See* App. 22-23. As the Sixth Circuit noted in *SIIA*, although "neither *Travelers* nor *De Buono* explicitly concerned reporting requirements regarding the taxes . . . those requirements were essential parts of the tax schemes and drew no comment." *SIIA*, 2014 WL 3804355, at *6. Moreover, the tax upheld in *De Buono* directly depleted plan assets.

Given this controlling precedent, the Second Circuit erred in holding that ERISA tolerates, at most, only a "slight reporting burden" on plans. App.

24. State laws of all kinds, from employment, licensing, and taxes to health and safety regulations, require "record-keeping, and filing with a third party." App. 24. It cannot be that ERISA preempts generally applicable state laws, unrelated to the objectives of ERISA, merely because those laws involve data collection or record-keeping.

3. The Second Circuit's refusal to apply the presumption against preemption also "flies in the face of clear Supreme Court precedent." App. 33 (Straub, J., dissenting). In a footnote, the court held that Vermont's law is not an exercise of the "states' historic police powers." App. 18 n.8. "[C]ollecting data," the majority opined, is not "historic" and "health data collection laws do not regulate the safe and effective provision of health care services." *Id.* This squarely conflicts with *De Buono*. *De Buono* held that New York's tax "clearly operates in a field that has been traditionally occupied by the States." 520 U.S. at 814 (quotation omitted). That was true even though the tax, first adopted in 1990, was a "revenue raising measure, rather than a regulation of hospitals." *Id.* at 809, 814; *see also id.* at 814 n.10 (fact that tax targets health care industry supports application of the presumption).[4]

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[4] The footnote concluded that "[i]n any event, the Supreme Court has repeatedly found the presumption overcome if the state laws 'upset the deliberate balance central to ERISA,' even if those laws 'implement policies and values lying within the traditional domain of the States.'" App. 18-19 n.8 (quoting *Boggs*

(Continued on following page)

Given the "considerable burden of overcoming" the presumption, *De Buono*, 520 U.S. at 814, Liberty Mutual's failure to prove any cost or administrative burden should have ended the inquiry. *See* App. 72-73 n.5 (district court); App. 39-41, 44 (Straub, J., dissenting). Yet the lower court assumed that Vermont's law was "burdensome" and "obviously intolerable." App. 25. Its judgment rested on speculation not just about Vermont's statute but about other states' laws and ways in which Vermont could change its program in the future. App. 25, 27-29. Consistent with this Court's precedents, the Second Circuit should have presumed the statute's constitutionality, not the opposite.

II. The Second Circuit's unduly broad preemption holding treads on state and federal interests and is an important issue worthy of this Court's immediate review.

The Second Circuit did not merely err in its application of precedent. The lower court returned to an expansive view of ERISA preemption that this Court has disavowed. Its flawed analysis of burden and cramped view of the states' historic police powers

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v. Boggs, 520 U.S. 833, 840, 854 (1997)). Nowhere in its analysis, however, does the majority apply the presumption against preemption or explain that the presumption is overcome. The lower court's holding, as the dissenting opinion recognizes, is that the presumption does not apply. App. 33 (Straub, J., dissenting).

will sow confusion and uncertainty. That is especially troubling in this context because, read literally, ERISA's preemption language suggests "a degree of pre-emption that no sensible person could have intended." *Dillingham*, 519 U.S. at 335-36 (Scalia, J., concurring). This Court should grant review to correct the Second Circuit's broad and unjustified expansion of ERISA preemption. And, as explained below, further review should be immediate because the Second Circuit's holding poses a serious threat to important state and federal interests.

A. The lower court's unwarranted expansion of ERISA preemption is a matter of exceptional importance to state legislators and regulators.

The Second Circuit's ruling threatens to undermine efforts by at least sixteen States to create and use databases similar to Vermont's. The breadth of the lower court's decision also casts a shadow over other state regulatory efforts in a field – health care – that is traditionally and primarily the responsibility of the States.

1. The Second Circuit's decision in this case undermines a widespread and crucial tool that States use to inform health care policy. At least ten other States have similar programs, known as all-payer

claims databases, already in place.[5] Five other States are creating databases,[6] and many more are considering doing so. Jo Porter et al., APCD Council, *The Basics of All-Payer Claims Databases* 1 (January 2014).[7] Claims databases are increasingly popular because states need "robust information about the costs and performance of their state's health care delivery system." Patrick B. Miller et al, State Coverage Initiatives, *All-Payer Claims Databases: An Overview for Policymakers* 2 (May 2010).[8] These databases "fill critical information gaps" and allow states "to understand the cost, quality, and utilization of health care for their citizens." *Id.*; Porter, *supra*, at 1. By collecting accurate, complete information about the provision of health care services, States are bringing transparency to the health care market, collecting

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[5] *Colorado*: Col. Rev. Stat. § 25.5-1-204; *Kansas*: Kan. Stat. Ann. § 65-6804; *Maine*: Me. Rev. Stat. Ann. tit. 22, §§ 8703, 8704; *Maryland*: Md. Code Ann., Health-Gen. § 19-133; *Massachusetts*: Mass. Gen. Laws Ann. ch. 12C, § 12; *Minnesota*: Minn. Stat. Ann. § 62J.321; *New Hampshire*: N.H. Rev. Stat. Ann. § 420-G:11-a; *Oregon*: Or. Rev. Stat. § 442.466; *Tennessee*: Tenn. Code Ann. § 56-2-125; *Utah*: Utah Code Ann. § 26-33a-106.1.

[6] *Connecticut*: Conn. Gen. Stat. § 38a-1091; *New York*: N.Y. Pub. Health § 2816; *Rhode Island*: R.I. Gen. Laws § 23-17.17-10; *Virginia*: Va. Code Ann. § 32.1-276.7:1; *West Virginia*: W. Va. Code § 33-4A-2.

[7] Available at: http://www.apcdcouncil.org/sites/apcdcouncil.org/files/The%20Basics%20of%20All-Payer%20Claims%20Databases.pdf.

[8] Available at: http://www.statecoverage.org/files/SCI_All_Payer_Claims_ReportREV.pdf.

critical cost information, and improving the quality of care.

Cost. It is impossible to overestimate the States' need for accurate and complete information about health care spending. The "projected growth in health-related costs" is the "primary driver of fiscal challenges for the state and local government sector in the long term." U.S. Government Accountability Office, *State and Local Governments' Fiscal Outlook* 5 (April 2012 Update).[9] Knowledge gaps "limit the ability to identify opportunities to address rising health care costs." Miller, *supra*, at 2. A true all-payers claims database provides this critical data. States may use this information to inform budgeting, rate-setting, and other policy decisions, and to measure the impact of reforms and pilot projects. *See, e.g.*, Chris Kardish, *More States Create All-Payer Claims Databases*, Governing (Feb. 4, 2014);[10] Miller, *supra*, at 2, 5; Porter, *supra*, at 2.

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[9] Available at: http://www.gao.gov/assets/590/589908.pdf. National spending on health care reached $2.79 trillion in 2012, more than double the level in 2000. Office of the Actuary, Centers for Medicare & Medicaid Services, *National Health Expenditures Tables*, Table 1, *available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf.

[10] Available at: http://www.governing.com/topics/health-human-services/gov-states-serious-about-health-data.html.

Transparency. State health care databases are bringing transparency to the health care marketplace. Lack of information about cost and quality is a serious problem for consumers, who "generally learn of their health care costs after receiving care, such as when they receive a bill." U.S. Government Accountability Office, *Health Care Price Transparency* 2 (September 2011).[11] Now, with a few keystrokes, consumers in some states have access to information that used to be burdensome or even impossible to find. Both Maine and New Hampshire, for example, have websites that allow consumers to compare costs across providers.[12] Other States are planning similar sites. *See* Christine Vestal, *Can Claims Data Crack the Health Care Cost Riddle?* USA Today (June 17, 2014) (discussing Utah and Colorado).[13]

Quality of Care. An all-payer claims database is a powerful public health tool. Policymakers can evaluate access to necessary services. Researchers can track chronic disease indicators, evaluate whether clinical care guidelines are met, and study specific problems such as adverse drug reactions and emergency room visits. Miller, *supra*, at 6-8. The data allow States not just to pinpoint problems but to

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[11] Available at: http://www.gao.gov/assets/590/585400.pdf.

[12] *See* Maine HealthCost, https://mhdo.maine.gov/healthcost 2014/ (last visited Aug. 3, 2014); New Hampshire HealthCost, http://www.nhhealthcost.org/ (last visited Aug. 3, 2014).

[13] Available at: http://www.usatoday.com/story/news/nation/2014/06/17/stateline-health-care-claims-data/10665577/.

assess whether proposed solutions are working. This "rich and deep source of health care data"[14] is a critical resource that States use to protect and improve the health and welfare of their citizens.

The Second Circuit's decision threatens these innovative programs. Self-insured ERISA plans, like Liberty Mutual's plan, provide coverage to millions of Americans. Nationally, over 60% of workers who receive health coverage through employment are in a self-funded plan. *See* Kaiser Family Foundation, *Employer Health Benefits 2013 Annual Survey*, at 176.[15] As the United States explained below, exempting self-insured plans from the database "would leave a large hole in the data collection the state has fashioned to further its state healthcare policies" and "seriously stymie Vermont's efforts to improve medical outcomes for its residents." U.S. Ct. App. Br. 10. Nothing in ERISA suggests that Congress wanted to create this kind of information vacuum.

This important question of ERISA preemption – relevant to at least sixteen States – is worthy of this Court's immediate review. The decision below does not address a new or emerging legal issue that needs further consideration in the lower courts. Rather, the

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[14] Utah All Payer Claims Database: Description and Background, http://health.utah.gov/hda/apd/about.php (last visited Aug. 3, 2014).

[15] Available at: http://kff.org/private-insurance/report/2013-employer-health-benefits/.

Second Circuit disregarded established precedent and returned to an expansive view of ERISA preemption that unacceptably limits state authority. Its decision governs not just Vermont's program, but also similar databases under development in New York and Connecticut. And all other States must administer (or establish) their programs under the cloud of that decision. The impact on these programs outweighs any negligible benefit from allowing the issue to develop further in the lower courts. Indeed, if this Court denies review, other states may adhere to the Second Circuit's ruling rather than risk litigation – reducing the likelihood any benefit will be gained from percolation.

2. Review is also warranted because the Second Circuit's broad holding has repercussions beyond these particular programs. As this Court recognized almost two decades ago, nothing in ERISA "indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. at 661. Yet the Second Circuit essentially held that any state record-keeping or information-gathering requirement intrudes on a "core" ERISA concern. App. 23-24. Many ordinary state health-care regulations and other health and safety standards require record-keeping and reporting of information. The Sixth Circuit correctly recognized, in *SIIA*, that such a broad view of ERISA preemption of state reporting requirements as extending to "paperwork" and record preservation is unworkable, and that "ERISA does not reach so

far." *SIIA*, 2014 WL 3804355, at *6. The Second Circuit's reasoning in this case creates uncertainty across a wide swath of traditional state regulation.

Regulation of hospitals and other health care services. As addressed in *De Buono*, ERISA plans may operate their own hospitals and health care centers. The provision of health care services is closely regulated by state law and routinely requires recordkeeping and reporting to state regulators. For example, States commonly require hospitals to provide frequent reports on finances, patient census, staffing levels and other quality and safety measures.[16] Under the Second Circuit's reasoning, these frequent reports would be preempted unless the State shows that the burdens imposed are "slight." App. 24.

Taxation. This Court held in *De Buono* that an ERISA plan must pay a generally applicable state tax on gross hospital receipts. 520 U.S. at 816. Courts have rejected preemption challenges to other state taxes, including a tax on covered health care claims. In *SIIA*, the Sixth Circuit rejected an ERISA preemption challenge to Michigan's tax on paid health care

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[16] *See, e.g.*, Conn. Gen. Stat. § 19a-654 (data submission); *id.* §§ 19a-644, 19a-649, § 19a-676 (hospital reports); 210 Ill. Comp. Stat. 85/25 (Hospital Report Card Act); N.Y. Comp. Codes R. & Regs, tit. 10, § 440.1 *et seq.* (hospital annual reports); Tex. Code Ann. § 257.005 (hospital staffing reports); *id.* § 311.033 (financial and utilization data); Vt. Stat. Ann. tit. 18, §§ 1854, 9405b (hospital reports).

claims, because the state law did not alter which benefits were offered, how they were calculated, or to whom they were disbursed, and thus did not interfere with plan administration. *SIIA*, 2014 WL 3804355, at *3-4. The court also held that the state law reporting and recordkeeping requirements at issue did not create improper administrative burdens for ERISA plans and thus did not conflict with ERISA's reporting obligations. *Id.* at *4-7.[17] *See also Boyle v. Anderson*, 68 F.3d 1093 (8th Cir. 1995) (rejecting ERISA preemption challenge to provider tax); *Thiokol Corp. v. Roberts*, 76 F.3d 751 (6th Cir. 1996) (rejecting ERISA challenge to state business tax). Taxes necessarily involve frequent and state-specific recordkeeping and reporting requirements – the same type of requirements that the Second Circuit found unacceptable in this case. The lower court's ruling thus creates uncertainty on an issue that was settled by *De Buono*.

Licensing and safety standards. ERISA plans may employ lawyers, to offer "prepaid legal services," and doctors, to offer medical and surgical care. 29 U.S.C. § 1002(1) (defining employee welfare plan).

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[17] The Sixth Circuit's suggestion that the Vermont database law "actually affects the administration of plans," *SIIA*, 2014 WL 3804355, at *7, is unsupported. Further, the Sixth Circuit, like the Second Circuit, offered no support for its conclusion that the creation of a database for the purposes of improving Vermonters' health outcomes and controlling the rate of health care cost growth is not an exercise of traditional state concern, and thus not entitled to the presumption against preemption.

Doctors and lawyers must comply with state licensing requirements, including reporting and recordkeeping requirements for professional education and client trust funds.[18] ERISA plans may operate day care centers, *id.*, which must be licensed and maintain detailed records showing compliance with state regulations.[19] Many ERISA plans run apprenticeship programs, which must satisfy state-law safety standards. *See, e.g., Wright Elec., Inc. v. Minn. State Bd. of Elec.*, 322 F.3d 1025, 1031-32 (8th Cir. 2003) (rejecting ERISA preemption challenge to state regulation mandating supervision of apprentices). The Third Circuit, which recently rejected a preemption challenge to a New Jersey prevailing wage law, noted that the law "require[d] that every contractor and subcontractor keep a record detailing the worker's name, his or her craft or trade, and actual hourly rate of wages paid to each worker." *N.J. Carpenters & Trs.*

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[18] For doctors, *see, e.g.*, N.J. Stat. Ann. § 45:9-7.1; Conn. Gen. Stat. § 20-10b; *see also* Medscape, State CME Requirements, http://www.medscape.org/public/staterequirements (last visited Aug. 3, 2014) (collecting requirements by state). For lawyers, *see, e.g.*, Cal. R. Prof. Conduct, Rule 4-100 (recordkeeping and audit requirements for client trust funds); N.Y. R. Prof. Conduct, Rule 1.15 (similar); Vt. R. Mandatory Continuing Legal Educ., § 9 (reporting requirements for continuing legal education); *see also* American Bar Association, Mandatory CLE, http://www.americanbar.org/cle/mandatory_cle.html (last visited Aug. 3, 2014) (collecting education requirements by state).

[19] *See, e.g.*, Vermont Early Childhood Program Licensing Regulations, § III(C) (Policies, Procedures, Records and Reports), *available at:* http://dcf.vermont.gov/sites/dcf/files/pdf/cdd/care/Early_Childhood_Program.pdf.

v. Tishman Constr. Corp., No. 13-3005, 2014 WL 3702591, at *2, 6 (3d Cir. July 28, 2014) (holding that state-law claim under prevailing wage law was not completely preempted by ERISA). Challenges to any of these state laws could easily be recast as objections to reporting or recordkeeping requirements.

The Sixth Circuit has observed that there is no "state-law-free zone around everything that affects an ERISA plan." *Assoc. Builders & Contractors v. Mich. Dep't of Labor*, 543 F.3d 275, 284 (6th Cir. 2008) (discussing potential consequences of a broad view of ERISA preemption). The Second Circuit's reasoning, however, risks just that result. And even if other courts ultimately narrow or decline to follow the Second Circuit's approach in this case, the lower court's ruling may generate another "avalanche" of ERISA litigation. *Cf. De Buono*, 520 U.S. at 809 n.1. The threat of litigation alone burdens States and influences state policy choices. The decision below thus has serious implications for state legislation and regulation far beyond the context of all-payer databases. It should not be allowed to stand.

B. The U.S. Department of Labor's appearance as an amicus in the court of appeals confirms that the scope of ERISA preemption is a pressing and important issue for the federal government.

The fact that the United States participated in this case as amicus curiae and argued against

preemption confirms the importance of the issue. The United States Department of Labor administers ERISA, including the law's reporting requirements. The Department took the unusual step of appearing as an amicus in the court of appeals to *defend* the decision of the district court. The Department's amicus filing shows that the scope of ERISA preemption is an important issue for the federal government, as well as the States.

The Second Circuit ignored the views of the United States and applied ERISA preemption far more broadly than the Department advocated. The Department, through its Employee Benefit Security Administration, creates and administers reporting requirements for ERISA plans. The Department explained to the court of appeals that Vermont's law does not conflict with ERISA's reporting requirements; that the "focus and purpose of Vermont's data collection" are "quite different" from ERISA's financial reporting and disclosure requirements; and thus the database statute "is like any other 'tenuous, remote or peripheral' law that requires information from businesses or other entities for regulatory purposes." U.S. Ct. App. Br. 12 (quoting *Travelers*, 514 U.S. at 661). Despite the Department's obvious expertise and interest, the panel majority did not even acknowledge the Department's position.

As the Department's amicus participation shows, the decision below adversely affects federal as well as state interests. The federal government has a substantial interest in the division of state and federal

regulatory authority in areas such as health care. Collecting claims data is not something the Department does and is not, in the Department's view, a matter with which ERISA is concerned. The federal government is careful to guard those areas that ERISA shields from state regulation, but it also recognizes the States' traditional authority over "'general health care regulation.'" U.S. Ct. App. Br. 10 (quoting *Travelers*, 514 U.S. at 661). By holding Vermont's law preempted, the Second Circuit has effectively challenged the Department's view of the scope and purpose of ERISA's reporting requirements.

The decision below broke sharply with this Court's controlling precedents, in a way that harms state interests and creates uncertainty for States and lower courts. Its sweeping expansion of ERISA preemption calls for immediate review.

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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August 13, 2014

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

August Term, 2013

(Argued: November 18, 2013 Decided: February 4, 2014)

Docket No. 12-4881-cv

----------x

LIBERTY MUTUAL
INSURANCE COMPANY,

Plaintiff-Appellant,

-v.-

SUSAN L. DONEGAN, IN HER CAPACITY
AS THE COMMISSIONER OF THE VERMONT
DEPARTMENT OF FINANCIAL REGULATION,

Defendant-Appellee.

----------x

Before: KEARSE, JACOBS, and STRAUB, *Circuit Judges.*

Liberty Mutual Insurance Co. appeals from a judgment entered in the United States District Court for the District of Vermont (Sessions, *J.*). The district court concluded that the Employee Retirement Income Security Act of 1974 does not preempt a Vermont statute and regulation requiring self-insured employee health plans to report to the state, in specified format, claims data and "other information relating to health care." For the following reasons, we

reverse and remand with instructions to enter judgment for Liberty Mutual.

Judge STRAUB dissents in part and concurs in part in a separate opinion.

NANCY G. ROSS, McDermott Will & Emery LLP, Chicago, IL (John A. Litwinski, McDermott Will & Emery LLP, Chicago, IL; M. Miller Baker, McDermott Will & Emery LLP, Washington, DC, *on the brief*), *for Appellant*.

BRIDGET C. ASAY, Assistant Attorney General, Office of the Attorney General, Montpelier, VT *for* William H. Sorrell, Attorney General, State of Vermont, *for Appellee*.

KATHRYN COMERFORD TODD, National Chamber Litigation Center, Washington, DC (Jane E. Holman, National Chamber Litigation Center, Washington, DC; Carol Connor Cohen and Nancy S. Heermans, Arent Fox LLP, Washington, DC, *on the brief*), *for amicus curiae Chamber of Commerce of the United States of America in support of Appellant*.

MELISSA MOORE, U.S. Department of Labor, Washington, DC (M. Patricia Smith, Solicitor of Labor; Timothy D. Hauser, Associate Solicitor; Nathaniel I. Spiller, Counsel for Appellate and Special Litigation, *on the*

brief), *for amicus curiae Acting Secretary of the United States Department of Labor in support of Appellee.*

DENNIS JACOBS, *Circuit Judge*:

Liberty Mutual Insurance Co. operates a self-insured employee health plan. A Vermont statute requires all "health insurers" (including self-insured plans) to file with the State reports containing claims data and other "information relating to health care." A State regulation specifies how such information must be recorded and transmitted.

When Vermont subpoenaed claims data from the Liberty Mutual plan's third-party administrator, this suit was commenced in the United States District Court for the District of Vermont (Sessions, *J.*). Liberty Mutual sought a declaration that the Employee Retirement Income Security Act of 1974 ("ERISA") preempts the Vermont statute and regulation. The district court granted summary judgment in favor of Vermont.

The ERISA preemption clause is not self-reading and ERISA preemption doctrine is not static. The early judicial consensus, based on the broad wording of the preemption clause (and legislative history), was to construe preemption broadly. More recent precedent has pulled back by setting a rebuttable presumption against preemption of state health care regulations. Two constants, however, remain: (1) recognition that ERISA's preemption clause is intended to avoid a multiplicity of burdensome state requirements

for ERISA plan administration; and (2) acknowledgment that "reporting" is a core ERISA administrative function. These two considerations lead us to conclude that the Vermont law, as applied to compel the reporting of Liberty Mutual plan data, is preempted. We therefore reverse and remand for entry of judgment in favor of Liberty Mutual.

BACKGROUND

I

The Vermont statute establishes and provides for the maintenance of "a unified health care database." Vt. Stat. Ann. tit. 18, § 9410(a)(1). The database "enable[s]" the State's Department of Banking, Insurance, Securities and Health Care Administration ("Department")[1] "to carry out [its] duties . . . , including":

> (A) determining the capacity and distribution of existing resources;
>
> (B) identifying health care needs and informing health care policy;
>
> (C) evaluating the effectiveness of intervention programs on improving patient outcomes;

---

[1] The Department is now called the Department of Financial Regulation. Many of the Department's health care database responsibilities were recently transferred to Vermont's Green Mountain Care Board. *See id.* § 9410.

> (D) comparing costs between various treatment settings and approaches;
>
> (E) providing information to consumers and purchasers of health care; and
>
> (F) improving the quality and affordability of patient health care and health care coverage.

Id.

To populate the database, the statute requires "[h]ealth insurers, health care providers, health care facilities, and governmental agencies" to "file reports, data, schedules, statistics, or other information," as the Department deems necessary, at the time and place and in the manner the Department requires. *Id.* at § 9410(c)-(d). The statute authorizes the Department to require the filing of "health insurance claims and enrollment information used by health insurers" and "any other information relating to health care costs, prices, quality, utilization, or resources." *Id.* at § 9410(c).

Knowing and willful failure to comply is punishable by penalty of not more than $10,000 per violation. *See id.* at § 9410(g).

In 2008, the Department promulgated a regulation to implement the statute and create the Vermont Healthcare Claims Uniform Reporting and Evaluation System (the "Reporting System"). *See* Regulation H-2008-01, 21-040-021 Vt. Code R. § 1 ("Regulation H-2008-01"). The regulation requires reporting of

myriad categories of claims data. *See infra* 26-29. "Health Insurers" are required to "regularly submit medical claims data, pharmacy claims data, member eligibility data, provider data, and other information relating to health care provided to Vermont residents and health care provided by Vermont health care providers and facilities to both Vermont residents and non-residents in specified electronic format to the Department for each health line of business . . . per the data submission requirements contained in" appendices to the regulation. Regulation H-2008-01 § 4(D).

A "[h]ealth insurer" is defined broadly to include "any health insurance company, . . . third party administrator, . . . and any entity conducting administrative services for business or possessing claims data, eligibility data, provider files, and other information relating to health care provided to Vermont residents or by Vermont health care providers and facilities." *Id.* § 3(X).

Begging the preemption question, the term "[h]ealth insurer" "may also include, *to the extent permitted under federal law,* any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities." *Id.* (emphasis added). A health insurer with 200 or more enrolled or covered members in each month during a calendar year is designated a "Mandated Reporter." *Id.* § 3(Ab). All other entities are "Voluntary Reporter[s]." *Id.* § 3(As).

The Department makes the collected data "available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in Vermont." Vt. Stat. Ann. tit. 18, § 9410(h)(3)(B). The Department decides "the extent" of such disclosure "allowed by HIPAA," the federal Health Insurance Portability and Accountability Act of 1996, *id.*, and maintains the "confidentiality code" by which filed information "is handled in an ethical manner," *id.* § 9410(f). "[D]irect personal identifiers," such as name, address, and Social Security number, may not be publicly disclosed. *Id.* § 9410(h)(3)(D).

Sixteen other states collect health care data for their own health care claims databases. J.A. 368-74 (State Health Reporting Laws Summary Table). Data submission requirements vary. Some states provide only for voluntary reporting. *See id.* Some expressly exclude self-insured employee plan data from their database reporting laws. *See id.* The majority, however, follow Vermont in requiring such plans to report claims data. *See id.*

II

Liberty Mutual Insurance Co. is the administrator and named fiduciary of a health plan (the "Plan") that provides benefits to 137 individuals in Vermont and to over 80,000 individuals nationwide. The Plan is "self-insured" or "self-funded," *i.e.*, health care claims are paid from Liberty Mutual's general assets.

Plan documents provide that the "Plan has been established for the exclusive benefit of Participants and except as otherwise provided . . . , all contributions under the Plan may be used only for such purpose." J.A. 39. The documents also represent that medical records, such as those related to risk factor screening, are kept "strictly confidential." J.A. 71-72. The Plan represents, however, that it "shall comply with all other state and federal law to the extent not preempted by ERISA and to the extent such laws require compliance by the Plan." J.A. 41.

Like many self-insured employer health plans, the Plan uses a third-party administrator ("TPA"). Blue Cross Blue Shield of Massachusetts, Inc. ("Blue Cross"), as the Plan's TPA for Vermont participants, does claims-handling: processing, review, and payment. Under its contract with Liberty Mutual, any information transferred to Blue Cross must be used solely for the purpose of administering the Plan, and Blue Cross auditors must guard against unauthorized disclosure of health care information. *See* J.A. 57-58. Liberty Mutual itself is a Voluntary Reporter because it has fewer than 200 covered members in Vermont (and has presumably decided not to volunteer); but because Blue Cross qualifies as a Mandated Reporter and possesses the Plan's claims data, the reporting of its data is mandatory.

In August 2011, Vermont issued a subpoena demanding that Blue Cross supply the Plan's "[e]ligibility files," "[m]edical claims files," and "[p]harmacy claims files" and threatened that noncompliance

might result in fines and a suspension of Blue Cross's authority to do business. J.A. 24-25. Liberty Mutual instructed Blue Cross not to comply and filed this suit, seeking (1) a declaration that ERISA preempts the Vermont statute and regulation; and (2) an injunction blocking enforcement of the subpoena. Vermont agreed to stay enforcement of the subpoena pending judicial resolution of the ERISA preemption question.

In dueling motions, Vermont sought to dismiss the complaint for lack of standing and for failure to state a claim, and Liberty Mutual moved for summary judgment. With the consent of the parties, the district court treated the motions as cross-motions for summary judgment. *See Liberty Mut. Ins. Co. v. Kimbell,* No. 2:11-cv-204, 2012 WL 5471225, at *1 (D. Vt. Nov. 9, 2012).

The court concluded that Liberty Mutual had Article III standing but that ERISA did not preempt the Vermont statute and regulation and that Vermont was therefore entitled to summary judgment. *See id.*

DISCUSSION

I

We agree with the district court that Liberty Mutual has standing to challenge the subpoena

issued to Blue Cross.[2] Liberty Mutual has demonstrated "the irreducible constitutional minimum of standing": (1) "an invasion of a legally protected interest which is (a) concrete and particularized; and (b) actual or imminent, not conjectural or hypothetical"; (2) "a causal connection between the injury and the conduct complained of"; and (3) that the injury will likely be redressed by a favorable decision. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992) (footnote, citations, and internal quotation marks omitted).

It is of no moment that the subpoena was issued to Blue Cross and not directly to Liberty Mutual. The TPA agreement provides that Liberty Mutual will hold Blue Cross harmless for any financial charges "arising from or in connection with" the Plan. J.A. 54-55. Liberty Mutual therefore faces a choice between (1) allowing Blue Cross to turn over the Plan's data in what Liberty Mutual considers a violation of its duties as Plan administrator and fiduciary; or (2) directing non-compliance, and indemnifying Blue Cross for the ensuing civil penalties. Either way, under *Lujan*, Liberty Mutual suffers a redressable injury-in-fact as a direct result of Vermont's threatened, imminent action.

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[2] The parties have not briefed the standing issue on appeal, but Article III standing "is the threshold question in every federal case, determining the power of the court to entertain the suit." *Warth v. Seldin*, 422 U.S. 490, 498 (1975).

II

We review *de novo* the grant of summary judgment on the preemption question. *See, e.g., Wrobel v. Cnty. of Erie,* 692 F.3d 22, 27 (2d Cir. 2012). Summary judgment is appropriate if the record shows "there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). "[W]e may reverse the grant of summary judgment and order judgment for the non-moving party if we find undisputed support in the record entitling the non-moving party to judgment as a matter of law." *New England Health Care Emps. Union v. Mount Sinai Hosp.,* 65 F.3d 1024, 1030 (2d Cir. 1995).

A

ERISA's comprehensive regulatory scheme governs most employee benefit plans, including self-insured health plans. *See* 29 U.S.C. § 1003. ERISA requires plan administrators to file annually with the Department of Labor reports detailing financial and actuarial information. *See id.* §§ 1021-1024. The Department of Labor is authorized "to undertake research and surveys and in connection therewith to collect, compile, analyze and publish data, information, and statistics relating to employee benefit plans." *Id.* § 1143. ERISA broadly preempts "any and all State laws insofar as they may now or hereafter *relate to any employee benefit plan.*" *Id.* § 1144(a) (emphasis added). With remarkable consistency, the

legislative history reflects that this broad wording was purposeful: it was intended to eliminate the threat of a multiplicity of conflicting or inconsistent state laws,[3] and to achieve broad preemptive effect in the areas of record-keeping, reporting, and disclosure.[4]

Vermont argues – and the district court agreed – that Congress could not have intended broad preemption of state reporting laws because the same Congress also passed the National Health Planning and

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[3] *See* 120 Cong. Rec. 29197 (1974) (Statement of Rep. Dent) ("I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation."); *id.* at 29933 (Statement of Sen. Williams) (discussing "inten[t] to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans" and stating that "[t]his principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law").

[4] *See* S. Rep. No. 93-127, at 35 (1973), *reprinted in* 1974 U.S.S.C.A.N. 4838, 4871 ("Because of the interstate character of employee benefit plans, the Committee believes it essential to provide for a uniform source of law in the areas of vesting, funding, insurance and portability standards, for evaluating fiduciary conduct, and *for creating a single reporting and disclosure system in lieu of burdensome multiple reports.*" (emphasis added)); H.R. Rep. No. 93-533, at 17 (1973), *reprinted in* 1974 U.S.S.C.A.N. 4639, 4655 (virtually the same); *see also* 120 Cong. Rec. 29942 (1974) (Statement of Sen. Javits) ("In view of Federal preemption, State laws compelling disclosure from private welfare or pension plans . . . will be superseded.").

Resources Development Act of 1974 ("NHPRDA"). The NHPRDA provided for the establishment of state health planning agencies and authorized these agencies to "assemble and analyze data concerning" health; health care delivery, resources, and use; and related environmental factors. *See* Pub. L. No. 93-641, 88 Stat. 2225, at § 1513(b) (1975). The Supreme Court consulted the NHPRDA to decide ERISA preemption in a case in which the NHPRDA expressly contemplated a state regulatory measure. *See N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 665-67 (1995). Here, however, the NHPRDA is not similarly indicative.[5] And if there were tension between NHPRDA and ERISA, it was relieved in 1986 when the NHPRDA was repealed.

B

The Supreme Court, and this Court, initially applied ERISA preemption as broadly as the statutory phrase ("relate to any employee benefit plan") seemed to require.

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[5] The NHPRDA's encouragement of state data collection is not necessarily inconsistent with ERISA's preemptive reach. A lot of data can be collected from health care providers, and from health care payers other than ERISA plans. Nothing in the NHPRDA compels the conclusion that, contrary to every indication in ERISA's text and history, Congress intended to allow a multiplicity of state record-keeping and reporting requirements for self-insured employee plans.

As explained in *Shaw v. Delta Air Lines, Inc.*, the "breadth of [ERISA's] pre-emptive reach is apparent from that section's language." 463 U.S. 85, 96 (1983); *see id.* at 98 ("Congress used the words 'relate to' . . . in their broad sense.").[6] *Shaw* formulated the modern ERISA preemption test: a state law is preempted if "it *[1] has a connection with* or *[2] reference to* [an ERISA] plan." *Id.* at 96-97 (emphases added). The Court treated as obvious that ERISA preempted "state laws dealing with the subject matters covered by ERISA – *reporting, disclosure,* fiduciary responsibility, and the like." *Id.* at 98 (emphases added). The open question was whether preemption went *beyond* these core areas, and the Court held it did. *See id.* at 96-97. The one note of caution in *Shaw* was consigned to a footnote:

> Some state actions may affect employee benefits plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law "relates to" the plan. Cf. *Am. Tel. & Tel. Co. v. Merry,* 592 F.2d 118, 121 (CA2 1979) (state garnishment of a spouse's pension income to enforce alimony and support orders is not pre-empted). The present litigation plainly does not present a border-line question, and we express no views about

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[6] That interpretation was supported by ERISA's exemption for generally applicable state criminal statutes, an exemption that would be unnecessary if preemption "applied only to state laws dealing specifically with ERISA plans." *Shaw,* 463 U.S. at 98 (discussing 29 U.S.C. § 1144(b)(4)).

> where it would be appropriate to draw the line.

Id. at 100 n.21.

For another decade, the Supreme Court and this Court followed *Shaw* and repeatedly emphasized the broad reach of ERISA preemption. *See, e.g., FMC Corp. v. Holliday,* 498 U.S. 52, 58 (1990) ("The pre-emption clause is conspicuous for its breadth."); *Gen. Elec. Co. v. N.Y. State Dep't of Labor,* 891 F.2d 25, 29 (2d Cir. 1989) ("ERISA was intended to have a 'sweeping preemptive effect in the employee benefit plan field.' Congress intended ERISA to occupy and regulate the field of employee benefit plans." (citation omitted)). The threat of conflicting state and local regulation was consistently cited as a paramount reason for preemption: Preemption "was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government." *Ingersoll-Rand Co. v. McClendon,* 498 U.S. 133, 142 (1990); *see Fort Halifax Packing Co. v. Coyne,* 482 U.S. 1, 10 (1987) ("We have not hesitated to enforce ERISA's pre-emption provision where state law created the prospect that an employer's administrative scheme would be subject to conflicting requirements. . . . Such a situation would produce considerable inefficiencies, which the employer might choose to offset by lowering benefit levels."); *Howard v. Gleason Corp.,* 901 F.2d 1154, 1157 (2d Cir. 1990) ("[T]he express pre-emption

provisions of ERISA are deliberately expansive, and designed to establish pension plan regulation as exclusively a federal concern in order to afford employers the advantages of a uniform set of administrative procedures governed by a single set of regulations." (citations and internal quotation marks omitted)).

These cases specifically re-emphasized that "reporting" and "disclosure" are core ERISA functions subject to a uniform federal standard. *See Ingersoll-Rand,* 498 U.S. at 137 ("[ERISA] sets various uniform standards, including rules concerning reporting, disclosure, and fiduciary responsibility. . . ."); *FMC Corp.,* 498 U.S. at 58 (listing "reporting" and "disclosure" as "subject matters covered by ERISA").

The Supreme Court has explained the importance of having uniform federal record-keeping and reporting requirements:

> [The legislative history] reflect[s] recognition of the administrative realities of employee benefit plans. An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and *keeping appropriate records in order to comply with applicable reporting requirements.* The *most efficient way to meet these responsibilities is to establish a uniform administrative scheme,* which provides a set of standard procedures to guide processing of claims and disbursement

> of benefits. Such a system is *difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States. A plan would be required to keep certain records in some States but not in others*; to make certain benefits available in some States but not in others; to process claims in a certain way in some States but not in others; and to comply with certain fiduciary standards in some States but not in others.

Fort Halifax, 482 U.S. at 9 (emphases added).

Liberty Mutual places great weight on the Supreme Court's summary affirmance of one of these early preemption cases, *Standard Oil Co. v. Agsalud*, 633 F.2d 760, 763 (9th Cir. 1980). We need not rest our ruling on that case or on so perfunctory a disposition as summary affirmance.[7] At the same time, it is

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[7] The district court in *Agsalud* held that a Hawaii law (1) requiring workers to be covered by a comprehensive prepaid health care plan and (2) imposing "certain reporting requirements which differ[ed] from those of ERISA," was preempted. 442 F. Supp. 695, 696, 706-07 (N.D. Cal. 1977). Though the ruling rested mainly on the state's comprehensive prepaid plan requirement, the court added that the ERISA preemption clause "was intended at the very least to preempt state laws regulating disclosure [and] reporting." *Id.* at 706 n.11. The Ninth Circuit agreed with the district court, 633 F.2d 760, 763 (9th Cir. 1980), and the Supreme Court summarily affirmed, *Agsalud v. Standard Oil Co.*, 454 U.S. 801 (1981). However, "the precedential effect of a summary affirmance extends no further than the precise issues presented and necessarily decided by those actions." *Anderson v. Celebrezze*, 460 U.S. 780, 784 n.5 (1983) (internal quotation marks omitted).

telling that when Congress amended ERISA in 1983 "to exempt from pre-emption certain provisions of the Hawaii Act," it "did not exempt from pre-emption those portions of the law dealing with reporting, disclosure, and fiduciary requirements." *Fort Halifax*, 482 U.S. at 13 n.7; *see* H.R. Rep. No. 97-984, at 18 (Dec. 21, 1982) (Conf. Rep.) ("The provision continues Federal preemption of State law with respect to matters governed by the reporting and disclosure and the fiduciary responsibility provisions of ERISA. . . .").

C

The Supreme Court's 1995 decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.* marked something of a pivot in ERISA preemption. *See* 514 U.S. 645 (1995). The Court began "with the starting presumption that Congress does not intend to supplant state law," especially if the "state action [occurs] in fields of traditional state regulation," like health care.[8] *Id.* at

[8] The dissent relies on this presumption. *See* Dissenting Op. at 4-5. We acknowledge that the presumption applies when the state law "operates in a field that has been traditionally occupied by the States," and that "the historic police powers of the State include the regulation of matters of health and safety." *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 (1997) (internal quotation marks omitted). However, state health data collection laws do not regulate the safe and effective provision of health care services, which is among the states' historic police powers. And collecting data can hardly be deemed "historic" – most such laws were enacted only within the last ten years. *See* J.A. 368-74. In any event, the Supreme Court has

(Continued on following page)

654-55. To preempt, a "clear and manifest purpose" by Congress is required. *Id.* at 655. Following on this presumption, the Court pulled back on its broad, literal reading of "relate to": if the phrase "were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course." *Id.*

Applying the two-part *Shaw* test in light of these new principles, the Court concluded that a state statute requiring hospitals to collect a surcharge from patients covered by commercial insurers was not preempted. *See id.* at 656. The Court explained that state law is preempted if it "mandate[s] employee benefit structures or their administration" or "provid[es] alternative enforcement mechanisms." *Id.* at 658. The state surcharge law withstood preemption in *Travelers* because it had no more than an "indirect economic influence" on ERISA plans, it did "not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself," and it did not "preclude uniform administrative practice or the provision of a uniform interstate benefit package if a plan wishes to provide one." *Id.* at 659-60.

The Court again recognized the central roles of reporting and disclosure: ERISA "controls the administration of benefit plans, as by imposing *reporting*

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repeatedly found the presumption overcome if the state laws "upset[ ] the deliberate balance central to ERISA," even if those laws "implement policies and values lying within the traditional domain of the States." *Boggs v. Boggs*, 520 U.S. 833, 840, 854 (1997).

and disclosure mandates." *Id.* at 651 (emphasis added) (citation omitted). "Congress's extension of pre-emption to all state laws relating to benefit plans was meant to sweep *more* broadly than state laws dealing with the subject matters covered by ERISA, *reporting, disclosure,* fiduciary responsibility, and the like." *Id.* at 661 (emphases added) (internal quotation marks and brackets omitted).

Applying *Travelers,* cases conclude that state laws having only an "indirect economic effect on ERISA plans" lack sufficient "connection with" or "reference to" an ERISA plan to "trigger ERISA preemption." *New England Health Care Emps. Union v. Mount Sinai Hosp.,* 65 F.3d 1024, 1030-33 (2d Cir. 1995); *see also De Buono v. NYSA-ILA Med. & Clinical Servs. Fund,* 520 U.S. 806, 809 (1997) (state hospital tax not preempted); *NYS Health Maint. Org. Conference v. Curiale,* 64 F.3d 794, 801-03 (2d Cir. 1995) ("[O]nly link [state surcharge law] has with ERISA plans is its indirect effect on rate diversification among insurers."). Nevertheless, the Supreme Court teaches that *Travelers* and its progeny do not disturb the long-standing principle that "state statutes that mandate[] employee benefit structures *or their administration*" have a "connection with" ERISA plans and are therefore preempted. *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr.,* 519 U.S. 316, 328 (1997) (emphasis added) (internal quotation marks omitted). Like *Travelers* itself, later cases reiterate that "ERISA is expressly concerned" with "reporting, disclosure, fiduciary responsibility, and the like." *Id.*

at 330 (internal quotation marks omitted); *see also Boggs v. Boggs*, 520 U.S. 833, 841 (1997); *Plumbing Indus. Bd. v. E.W. Howell Co.*, 126 F.3d 61, 66 (2d Cir. 1997).

The use of preemption to avoid proliferation of state administrative regimes also remains a vital feature of the law. "[D]iffering state regulations affecting an ERISA plan's system for *processing claims* and paying benefits impose precisely the burden that ERISA pre-emption was intended to avoid." *Egelhoff v. Egelhoff*, 532 U.S. 141, 150 (2001) (emphasis added) (internal quotation marks omitted); *see Romney v. Lin*, 94 F.3d 74, 80 (2d Cir. 1996) ("basic purpose" of ERISA preemption is to "avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans").

It is true that this Court's three most recent cases focus primarily on "the relationships among the core ERISA entities," and caution against preemption of generally applicable state laws. *See Stevenson v. Bank of N.Y. Co.*, 609 F.3d 56, 61 (2d Cir. 2010); *Hattem v. Schwarzenegger*, 449 F.3d 423, 429-31 (2d Cir. 2006); *Gerosa v. Savasta & Co.*, 329 F.3d 317, 324 (2d Cir. 2003). But these cases involve either a state income tax with only indirect economic effects (the kind of law *Travelers* expressly permits), *see Hattem*, 449 F.3d at 425, or state law causes of action that have "little to do with the conduct of the plan," *Gerosa*, 329 F.3d at 328; *see also Stevenson*, 609 F.3d at 61 (noting that state law suit did not implicate "actual administration" of the plan). They do not

purport to save state laws that subject plans to "sets of inconsistent state obligations" or that "tend to control or supersede central ERISA functions." *Gerosa,* 329 F.3d at 324, 328.

When this Court has allowed a state reporting requirement to withstand preemption, as it has in two post-*Travelers* cases, the requirement:

> (1) imposed no "particular form" of record-keeping and created burdens "so slight" as to "create[ ] no impediment to an employer's adoption of a uniform benefit administration scheme," *Burgio & Campofelice, Inc. v. NYS Dep't of Labor,* 107 F.3d 1000, 1009 (2d Cir. 1997) (internal quotation marks omitted); or
>
> (2) "sought information readily obtainable from an employer" without specifying "a particular form of record-keeping," *HMI Mech. Sys., Inc. v. McGowan,* 266 F.3d 142, 150-51 (2d Cir. 2001).

In effect, these cases adhere to the intact pre-*Travelers* principle against preemption of laws "creat[ing] no impediment to an employer's adoption of a uniform benefit administration scheme," *Fort Halifax,* 482 U.S. at 14, and with "too tenuous, remote, or peripheral" an effect on employee benefit plans, *Shaw,* 463 U.S. at 100 n.21. Thus *HMI* (which Vermont relies on heavily) cautioned that state subpoenas would indeed be "overbroad to the extent that they seek the amount of benefits that employees receive" or "examin[e] employer contributions on a benefit by benefit basis." *HMI,* 266 F.3d at 151.

D

We hold that the reporting requirements of the Vermont statute and regulation have a "connection with" ERISA plans (though no "reference to" them[9]) and are therefore preempted as applied. Our holding is supported by the principle (undisturbed in *Travelers*) that "reporting" is a core ERISA function shielded from potentially inconsistent and burdensome state regulation.[10]

ERISA preempts "state laws dealing with the subject matters covered by ERISA – *reporting, disclosure,* fiduciary responsibility, and the like." *Shaw,* 463 U.S. at 98 (emphases added). "[R]eporting" is necessarily a function distinct from the disclosure that administrators provide beneficiaries; otherwise "reporting"

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[9] The Vermont statute and regulation lack "reference to" an ERISA plan because they apply to all health care payers and do not act "exclusively upon ERISA plans." *Dillingham,* 519 U.S. at 325; *Travelers,* 514 U.S. at 656. A "connection with" an ERISA plan is sufficient, however, for preemption. *Shaw,* 463 U.S. at 96-97 (setting out disjunctive test).

[10] It is of no moment that the law is being applied to, and the subpoena targeted at, Liberty Mutual's TPA rather than Liberty Mutual itself. *See Pharm. Care Mgmt. Ass'n v. Dist. of Columbia,* 613 F.3d 179, 182 (D.C. Cir. 2010) (holding ERISA preempts state law provisions "insofar as they apply to a pharmaceutical benefits manager . . . under contract with an employee benefit plan (EBP) because they 'relate to' an EBP"). We agree with the D.C. Circuit that "the objective of uniformity in plan administration" is not "for some reason inapplicable simply because a plan has contracted with a third party to provide administrative services." *Id.* at 185.

would be subsumed by "disclosure" and rendered superfluous. Rather, "reporting" entails what Vermont requires be done: plan record-keeping, and filing with a third-party.

But whatever the scope of plan "reporting," Vermont cannot deny that that is what it is seeking. The relevant database is called the "Vermont Healthcare Claims Uniform *Reporting* and Evaluation System" and the operative section of the regulation is titled "*Reporting Requirements.*"[11] Regulation H-2008-01 §§ 3(Ar), 4 (emphases added).

Not every state law imposing a reporting requirement is preempted. *Burgio* and *HMI* allow a slight reporting burden to be laid on plans, consistent with the preemption rule tolerating laws that "create[ ] no impediment to an employer's adoption of a uniform benefit administration scheme," *Fort Halifax,* 482 U.S. at 14, and with "too tenuous, remote, or peripheral" an effect on employee benefit plans, *Shaw,* 463 U.S. at 100 n.21.

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[11] The dissent argues that the "reporting requirement imposed by the Vermont statute differs in kind from the 'reporting' that is required by ERISA and therefore was not the kind of state law Congress intended to preempt." Dissenting Op. at 1. But the conclusion does not follow from the premise. To the contrary: A hodge-podge of state reporting laws, each *more* onerous than ERISA's uniform federal reporting regime, and seeking different and additional data, is exactly the threat that motivates ERISA preemption.

But the reporting mandated by the Vermont statute and regulation is burdensome, time-consuming, and risky. Even considered alone, the Vermont scheme triggers preemption; considered as one of several or a score of uncoordinated state reporting regimes, it is obviously intolerable.

A quick overview of the Reporting System is telling:

- Plans must periodically report:

  (1) "medical claims data" "composed of service level remittance information for all non-denied adjudicated claims for each billed service including, but not limited to member demographics, provider information, charge/payment information, and clinical diagnosis and procedure codes, and . . . includ[ing] all claims related to behavioral or mental health";

  (2) "pharmacy claims data" "containing service level remittance information from all non-denied adjudicated claims for each prescription including, but not limited to: member demographics[,] provider information[,] charge/payment information[,] and national drug codes";

  (3) "member eligibility data" "containing demographic information for each individual member eligible for medical or pharmacy benefits for one or more days of coverage at any time during the reporting month";

(4) and any "other information relating to health care provided to Vermont residents and health care provided by Vermont health care providers and facilities to both Vermont residents and non-residents ... for each health line of business." Regulation H-2008-01 §§ 3-4.

- Plans must report their data frequently. Thus plans with 500 to 1,999 covered members must report *quarterly* and plans with 2,000 or more covered members must report *monthly*. *See id.* § 6(1). Compare this to ERISA, which requires a single report *annually*. *See* 29 U.S.C. § 1021.

- Data must be coded under the appropriate source code system. *See* Regulation H-2008-01 § 5(A)(5)(a). Sixteen source code systems are provided, including the "Admission Source Code" ("[a] variety of codes explaining who recommended admission to a medical facility") and the "International Classification of Diseases, 9th Revision, Clinical Modification" code ("describes the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and operations"). *Id.* Appendix A.

- "Individual data elements, data types, field lengths, field description/code assignments, and mapping locators" for each file must conform to specified requirements. *Id.* § 5(B). Fields include "Admission Hour" and "Discharge Hour," thirteen "Diagnosis" fields,

three "Procedure" fields, and the "Drug Name" and "Quantity Dispensed". *Id.* Appendices C-1-E-2.

- "[T]he social security number of the member/subscriber and the subscriber and member names" must be encrypted prior to submission by "utilizing a standard encryption methodology provided." *Id.* § 5(A)(5)(b). (Encryption is not required for other data fields.)

And nothing prevents the Department from changing these myriad requirements from time to time, so long as the Department complies with the broad mandate of the statute.

The confidentiality provisions of the Vermont scheme are complex but loose, and impair or (at least) reassign the obligation in the Plan documents to keep medical records strictly confidential, as well as the undertaking by Blue Cross as TPA to use information solely for Plan administration purposes and to prevent unauthorized disclosure.[12] The regulation specifically contemplates "access to health care claims data sets and related information" by "persons other than

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[12] Whether disclosure to Vermont is authorized under the Plan documents may turn on whether Vermont law creates authorization, because the Plan undertakes to comply with state law; but compliance is allowed only "to the extent not preempted by ERISA," a limitation that leaves the Plan and the TPA in a complex and expensive legal muddle.

the Department." *Id.* § 8. Each data field is classified into one of three "use and release" categories:

> (1) "Unavailable Data Elements": not available for general use and release.
>
> (2) "Restricted Data Elements": only available for use and release as part of a "Limited Use Research Health Care Claims Data Set" approved by the Department. These elements, and information that can be derived from these elements, include the member's city and zip code, the admission and discharge dates and hours, and the service provider and pharmacy names.
>
> (3) "Unrestricted Data Elements": "available for general use and public release. . . . upon written request." These publicly available elements, and information that can be derived from these elements, include the member's gender, age, medical coverage, prescription drug coverage, and diagnosis; the type of procedure; the service provider's speciality and zip code; and the name and price of any drugs prescribed.

Id. § 8 & Appendices J-1-J-14. Specific as these categories are, they may be illusory, because the Department can ease public release restrictions on data that is currently restricted or unavailable, so long as "direct" personal identifiers are not published and the data is (in the Department's opinion) handled in an "ethical manner." Vt. Stat. Ann. tit. 18, § 9410(e)-(f), (h)(3)(D).

Since other states can impose their own regimes for reporting – and many do – these burdens and risks must be multiplied.

The trend toward narrowing ERISA preemption does not allow one of ERISA's core functions – reporting – to be laden with burdens, subjected to incompatible, multiple and variable demands, and freighted with risk of fines, breach of duty, and legal expense.[13]

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[13] The dissent draws a "distinction between general administration and administration of plans, claims, and benefits" and concludes that ERISA preemption doctrine does not reach state reporting laws that implicate the former. Dissenting Op. at 14. Essentially, the dissent would preempt state reporting laws only if they require plans to submit financial statements. The dissent's view of ERISA plan "administration" and "reporting" is unduly narrow.

The overview of requirements (set out above) makes clear that Vermont requires ERISA plans to record, in specified format, massive amounts of claims information and to report that information to third parties, creating significant (and obvious) privacy risks and financial burdens that will be passed from the TPA to the Plan and from the Plan to the beneficiaries. That is not a proper allocation of plan assets. *See* 29 U.S.C. § 1104(a)(1)(A) ("[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries; and . . . defraying reasonable expenses of administering the plan[.]"). Modest financial burdens may be tolerable when the state laws imposing them do not directly implicate an ERISA core administrative concern. But the statute and regulation here require reporting of health claims, pharmacy claims, *etc.*, information about the essential functioning of employee health plans.

CONCLUSION

For the foregoing reasons, we reverse and remand with instructions to enter judgment for Liberty Mutual.

STRAUB, *Circuit Judge*, dissenting in part and concurring in part:

I respectfully dissent in part and concur in part.

I concur with part I of the discussion section of the majority opinion finding that Liberty Mutual has standing. For the reasons that follow, I dissent from the majority's holding that the Vermont statute is preempted by ERISA.

The majority finds that the burden imposed by the Vermont reporting requirement warrants preemption of the statute. This conclusion falters for two primary reasons. First, the reporting requirement imposed by the Vermont statute differs in kind from the "reporting" that is required by ERISA and therefore was not the kind of state law Congress intended to preempt. Second, Liberty Mutual has failed to show any actual burden, much less a burden that triggers ERISA preemption. Rather, the Vermont statute, like others we have previously upheld, does not interfere with an ERISA plan's administration of benefits. For these reasons, our precedent and that of the Supreme Court do not support the conclusion that the Vermont statute's reporting requirements pose the sort of threat to "the nationally uniform administration of

employee benefit plans" that would trigger preemption. *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1995) (hereinafter "*Travelers* ").

Looking at the objectives of ERISA and the impact of the Vermont statute on ERISA plans, as we must in order to determine whether the statute has an improper "connection with" ERISA plans, I conclude that this is not the type of statute that Congress intended to preempt.

ANALYSIS

The preemption clause of the ERISA statute provides that, with certain exceptions not relevant here, ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). The Supreme Court has stated that the "basic thrust of the preemption clause . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Travelers*, 514 U.S. at 657. "Pre-emption does not occur, however, if the state law has only a 'tenuous, remote, or peripheral' connection with covered plans, as is the case with many laws of general applicability." *Burgio & Campofelice, Inc. v. N.Y. State Dep't of Labor*, 107 F.3d 1000, 1008 (2d Cir. 1997) (internal quotations marks omitted) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 n.21 (1983)).

"Two kinds of state laws relate to ERISA for purposes of preemption: those that mandate employee benefit structures or their administration, and those that provide alternative enforcement mechanisms." *HMI Mech. Sys., Inc. v. McGowan,* 266 F.3d 142, 149 (2d Cir. 2001) (internal quotation marks and brackets omitted). The Vermont statute does neither. We have noted that courts are "reluctant to find that Congress intended to preempt state laws that do not affect the relationships among" "the core ERISA entities: beneficiaries, participants, administrators, employers, trustees and other fiduciaries, and the plan itself." *Gerosa v. Savasta & Co.,* 329 F.3d 317, 324 (2d Cir. 2003). The Vermont statute does not even arguably regulate these relationships. Moreover, the Vermont statute does not impose regulations on how plans are to be run or how benefits are to be administered.

Yet the majority takes up Liberty Mutual's invitation to give the term "reporting" its broadest meaning, and finds the statute is preempted because "reporting" is a "core ERISA function shielded from potentially inconsistent and burdensome state regulation." (Maj. Op. at 24-25) While it is certainly true that ERISA's core areas include "reporting, disclosure, [and] fiduciary responsibility," *Shaw,* 463 U.S. at 98, and that "state laws that would tend to control or supersede central ERISA functions . . . have typically been found to be preempted," *Gerosa,* 329 F.3d at 324, the majority's argument misses the nuance of what "reporting" means in the context of ERISA, and

ignores the case law's focus on whether the *administration of benefits to beneficiaries* is impacted, an issue on which there is no showing.

A. Traditional State Regulation of Health Care and the Presumption Against Preemption

The majority's finding, hidden in a footnote, that the presumption against preemption does not apply here, flies in the face of clear Supreme Court precedent instructing us to begin with the "presumption that Congress does not intend to supplant state law." *Travelers,* 514 U.S. at 654-55. "[I]n cases like this one where federal law is said to bar state action in fields of traditional state regulation, we have worked on the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Id.* at 655 (internal citations and quotation marks omitted). This is because "nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Id.* at 661.

The majority nonetheless holds that the presumption against preemption does not apply here because "state health data collection laws do not regulate the safe and effective provision of health care services." (Maj. Op. at 19 n.8) This contradicts the very Supreme Court precedent the majority relies upon: *DeBuono v. NYSA-ILA Medical and Clinical*

Services Fund, 520 U.S. 806 (1997). In that case, New York imposed a tax on patient services at various health care providers. 520 U.S. at 808. The Court applied the presumption, reasoning that although the New York law was "a revenue raising measure, rather than a regulation of hospitals, it clearly operates in a field that 'has been traditionally occupied by the States.'" *Id.* at 814. The Court further stated that the fact that the challenged law "targets only the health care industry . . . supports the application of the 'starting presumption' against pre-emption," because "the historic police powers of the State include the regulation of matters of health and safety." *Id.* at 814 & n.10. *DeBuono* is indistinguishable from the case at hand. Here, the Vermont statute "targets only the health care industry" and, even if it is not a regulation of health care entities, it certainly "operates in [the] field" of health and safety. Indeed, the stated purpose of the Vermont statute is to help improve health care quality. *See* Vt. Stat. Ann. tit. 18 § 9410(a)(1) (listing purposes, including "improving the quality and affordability of patient health care"). There should be no question, therefore, that the presumption applies here.

B. There is No Improper "Connection With" ERISA Plans

When analyzing whether ERISA preempts a state law, we apply the two-pronged *Shaw* test, as narrowed by *Travelers'* presumption against preemption. Under that test, we analyze whether a state law

has an impermissible "connection with" or "reference to" an ERISA plan. *See, e.g., Hattem v. Schwarzenegger,* 449 F.3d 423, 428 (2d Cir. 2006). Despite paying lip service to the *Shaw* test, the majority eschews a full analysis in favor of a talismanic recitation of the word "reporting."

I agree with the majority that because the Vermont statute requires data collection from entities other than ERISA plans, such as hospitals, health insurers, and pharmacy benefit managers, it "functions irrespective of the existence of an ERISA plan" and therefore does not make an improper "reference to" ERISA plans. *See Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.,* 519 U.S. 316, 328 (1997) (internal quotation marks and ellipsis omitted). The "connection with" prong, on which the majority hangs its hat, instructs us to examine both "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive" and the "effect of the state law on ERISA plans." *See Egelhoff v. Egelhoff ex rel. Breiner,* 532 U.S. 141, 147 (2001) (internal quotation marks omitted); *see also HMI,* 266 F.3d at 148 ("Analyzing a state law's 'connection' with ERISA plans requires the courts to consider ERISA's objectives and the effect of the state law on ERISA plans."). This analysis leads to the conclusion that the Vermont statute is not preempted.

1. Objectives of ERISA

The objectives of the ERISA statute are not in dispute. Congress "enacted ERISA in 1974 to respond to growing concerns about the risk of employers defaulting on pension plans, which were increasingly widespread but little regulated." *See* Mallory Jensen, *Is ERISA Preemption Superfluous In the New Age of Health Care Reform?*, 2011 Colum. Bus. L. Rev. 464, 472 (2011) (internal footnotes omitted); *see also* Brendan S. Maher and Peter K. Stris, *ERISA and Uncertainty*, 88 Wash. U. L. Rev. 433, 440 n.29 (2010) ("Few dispute that the statute was passed, in part, as a response to several high-profile pension defaults that arose from company failures that devastated the pensions of many workers.") (citing J.A. Wooten, *The Most Glorious Story of Failure in the Business: The Studebaker-Packard Corp. & the Origins of ERISA*, 49 Buff. L. Rev. 683, 683-84 (2001)). Indeed, the statute itself declares that, in passing ERISA, Congress sought to

> protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate

> remedies, sanctions, and ready access to the Federal courts.

29 U.S.C. § 1001(b).[1]

These objectives are reflected in the ERISA reporting and disclosure requirements, which are concerned with the mismanagement of funds and failure to pay employee benefits, and seek information on plan assets or allocation. *See* 29 U.S.C. § 1023 (requiring publication of annual report to include a financial statement of assets and liabilities, changes in fund balance, disclosures about changes made in the plan, and financial commitments, including loans, leases, and transactions, and an actuarial statement). The plain language of the ERISA reporting requirements shows that they are limited to the furnishing of a summary plan description to plan participants and an annual report to the Secretary. *See* 29 U.S.C. §§ 1021-30. The former is essentially a plain-English summary of key plan terms, *id.* §§ 1021-22, while the

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[1] The Supreme Court has also noted that Representative Dent, the House sponsor of the legislation, "represented that ERISA's fiduciary standards 'will prevent abuses of the special responsibilities borne by those dealing with plans,'" and that the "disclosure and reporting requirements 'will enable both participants and the Federal Government to monitor the plans' *operations*.'" *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 15 (1987) (quoting 120 Cong. Rec. 29197 and 29935 (1974)). "Senator Williams, the Senate sponsor, stated that these fiduciary standards would safeguard employees from 'such abuses as self-dealing, imprudent investing, and misappropriation of plan funds.'" *Id.* (quoting 120 Cong. Rec. 29932).

latter is concerned with the financial soundness of the plan, *id.* § 1023. Thus, under ERISA, plans must report information that goes to the financial integrity of the plan.

It is important to recognize that, as Liberty Mutual conceded at oral argument (Tr. at 9), the "reporting" required by ERISA is wholly distinct from the reporting sought by Vermont. As the majority describes in some depth, the Vermont statute seeks information on medical claims data, the services that have been provided to beneficiaries, charges and payments for those services, and demographic information about those receiving the coverage. (Maj. Op. at 26-29) At bottom, the state seeks to collect the information it needs to fulfill its role of providing health care to its citizens. Vermont does not seek information on plan assets, and does not review the allocation or denial of benefits, *see* Reg. H-2008-01, 21-040-021 Vt. Code R. § 5A(8) ("Denied claims shall be excluded from all medical and pharmacy claims file submissions"), the topics on which ERISA requires reports. Indeed, the Secretary of Labor, who oversees the reporting requirements and is responsible for enforcing and administering Title I of ERISA, has advised us that the focus and purpose of Vermont's data collection is different from the reporting requirements in ERISA. *See Amicus* Secretary of Labor Br. at 12.

This contrast between the objectives and reporting requirements of ERISA and those of the Vermont

statute suggests that the Vermont statute is not of the type that Congress intended to preempt.

2. Effect of the Vermont Statute on ERISA Plans

We look next to the effect of the Vermont statute on ERISA plans. The Vermont statute asks for after-the-fact information which plan administrators, such as Blue Cross Blue Shield of Massachusetts ("BCBSMA"), already have in their possession. *See* Tr. at 7-8. Indeed, by all accounts BCBSMA is happy to provide the data Vermont has asked for, and it does so for other clients. Because Liberty Mutual possesses all the information Vermont seeks, the only alleged burden here is providing the data to Vermont in the requested format.

The majority finds that there is an obvious burden connected with the formats and requirements specified by Vermont, although it does not explain exactly how that burden manifests itself. Perhaps this is because Liberty Mutual has failed to provide any details or showing of the alleged burden, arguing only that "all regulations have their costs." Appellant's Br. at 28. *See also* Br. for *Amicus* Chamber of Commerce at 9 (increased steps required by a TPA to fulfill requirements) and 10 (arguing generally that additional requirements will "cost additional money").

In as much as this burden is a financial one, as Liberty Mutual suggests, we have stated clearly, as has the Supreme Court, that indirect financial costs

from a state law are not a concern unless they "preclude uniform administration practice or the provision of a uniform interstate benefit package." *Travelers,* 514 U.S. at 660. Indeed, our case law addressing statutes which impose added costs on ERISA plans states clearly that an indirect economic impact is sufficient to trigger preemption only if it "produce[s] such acute, albeit indirect, economic effects as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers." *Travelers,* 514 U.S. at 668; *see also Aetna Life Ins. Co. v. Borges,* 869 F.2d 142, 147 (2d Cir. 1989) (noting that "indirect economic and administrative effects are not substantial enough . . . to persuade us that this is the type of law Congress intended to preempt" and upholding Connecticut escheat law requiring Aetna to pay all unclaimed benefits to the State after three years, even though this would cause, *inter alia,* an increase in premiums to employers, lower benefits for employees, and lower profits for Aetna).[2] On the record before us, there is no basis to find that the Vermont statute would cause Liberty Mutual to increase its costs more than a *de minimus* amount to cover the cost of sending

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[2] The majority claims that "modest financial burdens" are only "tolerable when the state laws imposing them do not directly implicate an ERISA core concern," (Maj. Op. at 31 n.13) without citing to any authority. This statement is directly contradicted by *Borges,* where financial burdens were acceptable despite implicating one of the most central ERISA concerns: the payment of benefits.

information to the state, much less that it would cause a fiduciary to change a plan in any way. *See DeBuono,* 520 U.S. at 815 (noting that many state laws of "general applicability" will "impose some burdens on the administration of ERISA plans, but nevertheless do not 'relate to' them within the meaning of" ERISA).

The majority also suggests the Vermont statute is inconsistent with ERISA because of its supposed inconsistencies with other state reporting regimes. To reach this conclusion, the majority relies on language from *Fort Halifax Packing Co. v. Coyne,* 482 U.S. 1 (1987), suggesting that ERISA preempts laws which create conflicting state record-keeping requirements. (Maj. Op. at 17-18) *Fort Halifax* involved a preemption challenge to a Maine statute requiring an employer to provide a one-time severance payment to employees under certain circumstances. 482 U.S. at 3. The Supreme Court found that the statute regulated employee benefits but did not regulate or establish an employee benefit "plan," and thus was not preempted by ERISA. *Id.* at 6-8.

The dicta in *Fort Halifax* on which the majority relies does not bear the weight the majority places upon it. To the extent *Fort Halifax* suggests that a state law may not require an ERISA plan to keep records it would not otherwise keep, that concern is not implicated here. The Vermont statute does not require plan administrators to keep any new records, it merely seeks access to the records that are already

kept. *Fort Halifax* does not say anything about when or how a state may demand access to existent records.

Moreover, the language in *Fort Halifax* describing the "administrative realities of employment benefit plans," does not relate to all administrative concerns, but rather to the repeatedly articulated concern that there be "nationally uniform administration *of employee benefit plans.*" *Travelers,* 514 U.S. at 657 (emphasis added). *See Fort Halifax,* 482 U.S. at 9 (suggesting it is most efficient for plans to have "a uniform administrative scheme, which provides a set of standard procedures to guide *processing of claims and disbursement of benefits.*" (emphasis added)).

The distinction between general administration and administration of plans, claims, and benefits is important. Many state laws may have an impact on the administration of an ERISA plan – for example, a work-place safety law, a prevailing wage law, or a law that requires companies to report employment data. Such laws may impose additional costs, or require additional administrative resources. But none of these laws impact *how benefits are administered to beneficiaries* and, therefore, they are not preempted by ERISA. *See, e.g., Dillingham,* 519 U.S. at 319 (upholding California prevailing wage law); *HMI,* 266 F.3d at 144 (upholding New York prevailing wage law); *Burgio,* 107 F.3d at 1003 (same). The reason for our focus on whether a state statute affects the relationships among "the core ERISA entities: beneficiaries, participants, administrators, employers, trustees and other fiduciaries," *see Gerosa,* 329 F.3d at 324, is

because the concern is about whether the *administration of benefits to beneficiaries* is affected. The majority ignores this distinction and treats all administrative burdens as weighing in favor of preemption.

The importance of separating any impact on the administration of benefits from general impact upon any administrative concern is clearly articulated in *Egelhoff v. Egelhoff ex rel. Breiner,* which involved a Washington state statute providing that "the designation of a spouse as the beneficiary of a nonprobate asset is revoked automatically upon divorce." 532 U.S. at 143. There, the Supreme Court stated that while "all state laws create some potential for a lack of uniformity," the concern was specifically whether "differing state regulations affect[ ] an ERISA plan's 'system for processing claims and paying benefits.'" *Id.* at 150 (quoting *Fort Halifax,* 482 U.S. at 10). The Court noted that the Washington statute at issue "interfere[d] with nationally uniform plan administration," as administrators could not "make payments simply by identifying the beneficiary specified by the plan documents" but instead had to "familiarize themselves with state statutes so that they c[ould] determine whether the named beneficiary's status has been 'revoked' by operation of law." *Id.* at 148-49. In clear contrast to *Egelhoff,* there is no argument here that the Vermont statute affects Liberty Mutual's "system for processing claims and paying benefits." *Id.* at 150 (internal quotation marks omitted).

It follows from these precedents that in order to show that the Vermont statute has a legally relevant

effect on ERISA plans, there must be evidence of a burden on the system for processing claims. No such evidence has been provided, and the majority points to none. The only possible conclusion on the record before us is that, other than through potential incidental costs, the Vermont statute does not hinder the national administration of employment benefit plans in any way. No new records need be kept, no distinction in benefits between Vermont and any other state need be made. This ends the inquiry.[3]

C. Reporting Requirements Upheld in *HMI* and *Burgio*

Using this same analysis, we twice concluded that ERISA did not preempt the reporting requirements in New York's prevailing wage law. *See HMI*, 266 F.3d 142; *Burgio*, 107 F.3d 1000. In both cases, the New York statute at issue required contractors and subcontractors to produce records showing their

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[3] Any support that the majority draws from *Standard Oil Co. v. Agsalud*, 633 F.2d 760, 763 (9th Cir. 1980), is misplaced. See Maj. Op. at 18-19. The Ninth Circuit opinion, which the Supreme Court summarily affirmed, does not even mention the reporting requirement in the Hawaii Prepaid Care Act. The Hawaii statute was found to be preempted because it directly and expressly regulated employers and the benefits they provided. The reporting requirement fell along with the rest of the statute *without* discussion. The fact that Congress did not amend ERISA to except reporting or disclosure requirements says nothing about whether a court asked to evaluate such requirements would find them to be preempted.

compliance with the prevailing wage rate and supplements. *See Burgio,* 107 F.3d at 1009; *HMI,* 266 F.3d at 151; N.Y. Lab. Law § 220. In *HMI,* we noted that although there were indirect effects on ERISA plans, such as "eliminating incentives for them to pool supplement contributions," the state's inquiry did not "mandat[e] a particular benefit structure for ERISA plans," "require employers or ERISA plans to provide specific benefits," or delve into the internal allocations of benefits within the plan. 266 F.3d at 150-51; *see also Burgio,* 107 F.3d at 1009 (finding no preemption where law did not "regulate . . . the terms and conditions of employee benefit plans", "prescribe [] . . . the type and amount of an employer's contribution to a plan", or the "nature and amount of the benefits provided"). Rather, we said that "information such as a list of plan participants, payroll lists, the amount of an employer's contributions and the names of people for whom the employer made contributions are appropriate areas of inquiry" for the state. *HMI,* 266 F.3d at 151. Both opinions make clear that a state may properly seek information from ERISA plans for its own purposes without triggering preemption so long as the request for information "creates no impediment to an employer's adoption of a uniform benefit administration scheme," *Burgio,* 107 F.3d at 1009. As discussed above, the Vermont statute creates no such impediment, and therefore survives under the same analysis.

The majority attempts to distinguish these cases based on the manner in which Vermont asks to be

provided information. But the fact that a particular format is required, without more, is meaningless. The record contains no evidence that the burden of providing data to Vermont (and other states which may ask for it) would keep plans from administering their benefits uniformly and therefore trigger ERISA preemption. Likewise, the majority's statement that the reporting requirement is "time-consuming and risky" (Maj. Op. at 26) – even if considered relevant under our precedent – is nothing more than pure speculation. There is no evidence to support such a finding.

CONCLUSION

Returning, then, to the language that must guide our inquiry, our decision depends on the objectives of the ERISA statute and the effect of the state law on ERISA plans. Although Congress intended to establish the regulation of employee benefit plans as an exclusively federal concern, it did not intend for health care to become the exclusive purview of the Federal Government. Rather, it anticipated that the States would continue to be involved in providing health care services to their citizens.

Liberty Mutual fails to overcome the presumption against preemption. The Vermont statute regulates health care within that state, while imposing a purely clerical burden on ERISA plans. I acknowledge that because Vermont may not be the only state with this type of law, plans governed by ERISA may need to provide their records in different formats. But our

case law does not support a finding that this warrants preemption. Indeed, it says uniformly that an economic burden imposed by a statute of general applicability, which does not affect the benefits that beneficiaries receive or how they receive them, is permissible.

Because the Vermont statute does not have an impermissible "connection with" ERISA plans, I respectfully dissent.

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF VERMONT

LIBERTY MUTUAL INSURANCE COMPANY,	:	
Plaintiff,	:	
v.	:	
STEPHEN W. KIMBELL, in his capacity as the Vermont Commissioner of Banking, Insurance, Securities and Health Care Administration,	:	Case No. 2:11-cv-204
Defendant.	:	

OPINION and ORDER

(Filed Nov. 9, 2012)

Plaintiff Liberty Mutual Insurance Company ("Liberty Mutual") seeks a declaration that Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a), preempts Vermont's statute and regulation requiring it to provide information for the State's health care database, *see* Vt. Stat. Ann. tit. 18, § 9410 (2000 & Supp. 2011); Reg. H-2008-01, and to enjoin the enforcement of a subpoena directing the production of eligibility, medical claims and pharmacy claims files. Defendant Stephen W. Kimbell, in his official capacity as Commissioner of the Vermont Department of Banking,

Insurance, Securities and Health Care Administration ("BISHCA" or "Department"),[1] moved to dismiss the complaint for lack of standing and for failure to state a claim upon which relief can be granted. *See* Fed. R. Civ. P. 12(b)(1), 12(b)(6). Liberty Mutual moved for summary judgment. *See* Fed. R. Civ. P. 56(a). At oral argument on the motions, with the parties' concurrence, the Court converted the Department's Rule 12(b)(6) motion to one for summary judgment under Rule 56(a), in order to consider materials submitted outside the pleadings. *See* Fed. R. Civ. P. 12(d). For the reasons that follow, the Court concludes that Liberty Mutual has standing to bring this suit for declaratory and injunctive relief, but that the Department's motion for summary judgment is granted because ERISA does not preempt section 9410. Accordingly, the Department's Motion to Dismiss, ECF No. 15, is **granted in part and denied in part**. The motion is denied with respect to standing and granted with respect to ERISA preemption. Liberty Mutual's Motion for Summary Judgment, ECF No. 35, is **denied**. Liberty Mutual's Motion for Leave to Respond to Defendant's Notice of Supplemental Authority, ECF No. 52, is **granted**.

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[1] BISHCA has been renamed, and is now the Department of Financial Regulation ("DFR").

Background[2]

Liberty Mutual is an insurance company organized under the laws of the Commonwealth of Massachusetts. It is a wholly owned subsidiary of Liberty Mutual Group Inc. Liberty Mutual has employees and offices in Vermont and conducts business within the state.

Liberty Mutual established the Liberty Mutual Medical Plan ("Plan") for the benefit of company employees. As of June 30, 2011, the Plan provided medical benefits to 84,711 persons throughout the United States, including 32,933 employees of Liberty Mutual Group, Inc. and its subsidiaries, plus employees' families and company retirees. As of that date, 137 plan participants or beneficiaries resided in Vermont.

As an employee welfare benefit plan, the Plan is governed by ERISA. Liberty Mutual is the "named fiduciary" and "plan administrator" of the Plan within the meaning of Section 3 of ERISA, 29 U.S.C. § 1002. The Plan is self-funded, or self-insured, meaning that Liberty Mutual Group, Inc. pays all benefits provided under the Plan from its own general assets. The Plan contracts with Blue Cross Blue Shield of Massachusetts, Inc. ("BCBSMA") as the third-party administrator ("TPA") of the Plan. As such, BCBSMA processes medical claims for Plan participants, receives participants'

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[2] The facts set forth in this section are undisputed.

confidential medical records and generates claims data. The Administrative Services Agreement ("Agreement") between BCBSMA and Liberty Mutual provides that any information Liberty Mutual makes available must be used solely for the purpose of administering BCBSMA's health care plans, and that its auditors must have procedures in place to guard against unauthorized disclosure of health care information. *See* Agreement §§ 5, 6; ECF No. 22-4.

In Liberty Mutual's summary plan description ("SPD"), provided to participants, Liberty Mutual informs participants that information they provide in connection with screening for risk factors will be kept strictly confidential, and that if they participate in genetic testing the test is confidential. *See* SPD "Well-Baby Programs" at B-28, "Personalized Medicine Program" at B-46; ECF No. 22-5.

Liberty Mutual's Plan specifies that it "has been established for the exclusive benefit of Participants. . . ." *See* Plan § 9.1; ECF No. 22-2. It also provides that the Plan "shall comply with all other state and federal law to the extent not preempted by ERISA and to the extent such laws require compliance by the Plan." *Id.* § 9.9.

Liberty Mutual's Plan is subject to federal reporting and disclosure requirements set forth in ERISA Sections 101 through 110 and associated regulations. *See* 29 U.S.C. §§ 1021-1031; 29 C.F.R. §§ 2520.101-1 to 2520.107-1. In addition, Section 513 of ERISA authorizes the Secretary of Labor to "undertake

research and surveys and in connection therewith to collect, compile, analyze and publish data, information, and statistics relating to employee benefit plans. . . ." 29 U.S.C. § 1143(a).

Vermont has enacted legislation to create a unified health care database. *See* Vt. Stat. Ann. tit. 18, § 9410 (2000 & Supp. 2011). The database, established and maintained by the Department, is designed to enable the Department to determine the capacity of existing resources, identify health care needs, evaluate effectiveness, compare costs, provide information to consumers and purchasers of health care, and improve the quality and affordability of patient health care and health care coverage. *See* § 9410(a)(1)(A)-(F).

Section 9410 requires "health insurers," which includes "any . . . entity with claims data . . . and other information relating to health care provided to Vermont resident[s]," § 9410(j)(1)(B), to "file reports, data, schedules, statistics, or other information determined by [the Department] to be necessary to carry out the purposes of" the statute. § 9410(c). The statute mandates the adoption of rules to carry out its purposes, § 9410(a)(2)(D), and provides for administrative penalties for knowing and for willful failure to comply with the statute or rules. § 9410(g).

Pursuant to the statute, the Department promulgated Regulation H-2008-01 to implement the creation of the unified health care database. It states:

> The purpose of this rule is to set forth the requirements for the submission of health care claims data, member eligibility data, and other information relating to health care provided to Vermont residents . . . by health insurers,. . . . third party administrators, . . . and others to the [DFR] and conditions for the use and dissemination of such claims data, all as required by and consistent with the purposes of . . . § 9410.

Reg. H-2008-01, § 1. The Vermont Healthcare Claims Uniform Reporting and Evaluation System ("VHCURES") is the Department's system for the collection, management and reporting of this data. *See id.* § 3Ar.

The regulation tracks the statute in defining "health insurer" to include entities defined in § 9410(j)(1), including

> any third party administrator . . . and any entity . . . possessing claims data, eligibility data, provider files, and other information relating to health care provided to Vermont residents or by Vermont health care providers and facilities. The term may also include, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities.

Id. § 3X.

The parties do not dispute that Liberty Mutual and BCBSMA fall within the regulation's definition of "health insurer."

The regulation requires health insurers to register with the Department, and to identify whether health care claims are being paid for members who are Vermont residents or for non-residents who are receiving covered services from Vermont health care providers or facilities. *See id.* § 4A. Health insurers must "regularly submit medical claims data, pharmacy claims data, member eligibility data, provider data, and other information relating to health care provided to Vermont residents and health care provided by Vermont health care providers and facilities to both Vermont residents and non-residents in specified electronic format." *Id.* § 4D. The regulation sets a threshold for "mandated reporters," those health insurers with two hundred or more enrolled or covered members. *Id.* § 3Ab. All other health insurers are considered "voluntary reporters." *Id.* § 3As. Voluntary reporters may, but are not required to, participate in VHCURES. *See id.* § 4E.

The statute and regulation include various measures designed to protect confidential material. *See* §§ 9410(a)(2)(D) ("The rules shall permit health insurers to use security measures designed to allow subscribers access to price and other information without disclosing trade secrets to individuals and entities who are not subscribers."); (e) ("Records or information protected by the provisions of the physician-patient privilege . . . or otherwise required by

law to be held confidential, shall be filed in manner that does not disclose the identity of the protected person."); (f) (The commissioner shall adopt a confidentiality code to ensure that information obtained under this section is handled in an ethical manner."); (g) ("[A]ny person who knowingly fails to comply with the confidentiality requirements of this section or confidentiality rules adopted pursuant to this section and uses, sells, or transfers the data or information for commercial advantage, pecuniary gain, personal gain, or malicious harm shall be subject to an administrative penalty of not more than $50,000.00 per violation."); (h)(2)(D) ("Notwithstanding [the Health Insurance Portability and Accountability Act ("HIPAA")] or any other provision of law, the comprehensive health care information system shall not publicly disclose any data that contains direct personal identifiers. . . ."); *see also* Reg. H-2008-01 §§ 5(A)(5) (setting forth code and encryption requirements); 7(A)(5) ("Files submitted shall not contain direct personal identifiers."); 8(A) (classifying data elements as "unrestricted" and available for general use and public release; "restricted" and available for limited approved research uses; or "unavailable").

Subject to these strictures and the requirements of HIPAA, the statute and regulation allow the Department to make the data it collects "available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in Vermont." § 9410(h)(3)(B).

On August 5, 2011, the Department issued a subpoena to BCBSMA seeking eligibility, medical claims and pharmacy claims files for certain months. Liberty Mutual instructed BCBSMA not to report the information for Plan participants and beneficiaries, and filed this action seeking declaratory and injunctive relief. BCBSMA has complied with the subpoena with the exception of providing the data collected on the Vermont participants in Liberty Mutual's Plan, and has indicated that it will comply fully with the subpoena absent injunctive relief from this Court. *See* Verified Compl. ¶ 39, ECF No. 1.

The subpoena served on BCBSMA states that

> [p]ursuant to 8 V.S.A. § 13(b), a person who fails or refuses to produce papers or records for examination before the Commissioner, upon properly being ordered to do so, may be assessed an administrative penalty of the Commissioner of not more that [sic] $2,000.00 for each day of noncompliance and proceeded against as provided in the Administrative Procedure Act, and that person's authority to do business may be suspended for not more than six months.

Subpoena, ECF No. 1-1.

Discussion

I. Standing

The Department challenges Liberty Mutual's Article III standing. Standing, a "threshold question

in every federal case, determin[es] the power of the court to entertain the suit." *Warth v. Seldin,* 422 U.S. 490, 498 (1975). The "irreducible constitutional minimum of standing" requires a plaintiff to show (1) that it has "suffered an injury in fact – an invasion of a legally protected interest which is (a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical; [(2)] a causal connection between the injury and the conduct complained of; [and (3) that it is] likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision." *Lujan v. Defenders of Wildlife,* 504 U.S. 555, 560 (1992) (citations and internal quotation marks omitted); *accord Carver v. City of New York,* 621 F.3d 221, 225 (2d Cir. 2010).

Because Liberty Mutual's standing is challenged by a Rule 12(b)(1) motion to dismiss, the Court accepts as true all material allegations of the complaint, and construes the complaint in Liberty Mutual's favor. *Id.* The Court also accepts the sworn declaration of Mary Connolly, ECF No. 22-1, with its attached exhibits, including copies of the Plan, the Summary Plan Description, and the Administrative Services Agreement between Liberty Mutual and BCBSMA. *See Warth,* 422 U.S. at 501.

The Department contends that Liberty Mutual cannot establish the first or second elements of Article III standing: concrete injury or causal connection. The Department points out that the subpoena is directed toward BCBSMA, not Liberty Mutual, and that it does not seek data from Liberty Mutual.

Therefore, it reasons, Liberty Mutual can suffer no injury if BCBSMA complies with the subpoena. Liberty Mutual responds that it has standing because it is the Plan fiduciary, and providing the data to the Department, or allowing the data to be provided, could constitute a violation of its fiduciary duties. It also asserts that the Plan owns the data demanded by the Department. *See* Verified Compl. ¶ 35.

Liberty Mutual is the Plan Administrator, and has control over the operation and administration of the Plan. Plan §§ 7.1-7.2. It is a fiduciary with respect to the Plan, given that it "exercises . . . discretionary authority or discretionary control respecting management" of the Plan. 29 U.S.C. § 1002(21)(A); *see Fin. Insts. Ret. Fund v. Office of Thrift Supervision,* 964 F.2d 142, 148 (2d Cir. 1992). Either by virtue of its plan administrator responsibilities or its fiduciary responsibilities, it has the authority to direct BCBSMA to refuse to provide Plan data to the Department.

It is undisputed that, as a voluntary reporter, Liberty Mutual itself may not be compelled to provide data to VHCURES. BCBSMA however is a mandated reporter, and is subject to section 9410's reporting requirements with respect to Liberty Mutual's Plan's data along with the data it acquires from other sources. When a plaintiff's asserted injury arises from the allegedly unlawful regulation of a third party, the plaintiff must "adduce facts" showing that the third party will act in such a fashion "as to

produce causation and permit redressability of injury." *Lujan*, 504 U.S. at 562.

According to the terms of the contract between BCBSMA and Liberty Mutual, Liberty Mutual agrees to hold BCBSMA harmless for any financial charges that may result at any time arising from or in connection with its self-insured ERISA health benefit plan. Agreement § 2. Liberty Mutual will therefore be responsible for any civil penalties assessed against BCBSMA because of BCBSMA's refusal to comply with the subpoena. The Department does not indicate that it will forbear enforcement of the subpoena directed to BCBSMA, and there is no suggestion that the threat of civil penalties is remote or speculative.

The Department's issuance of a subpoena to BCBSMA leaves two options open to Liberty Mutual. Liberty Mutual may allow BCBSMA to comply with the subpoena, allegedly in violation of ERISA and Liberty Mutual's fiduciary and administrative responsibilities to the Plan. Or Liberty Mutual may demand that BCBSMA refuse to comply with the subpoena, in which case it must indemnify BCBSMA if BCBSMA incurs civil penalties for its refusal, or sue BCBSMA if BCBSMA complies with the subpoena. As long as Liberty Mutual employs a mandated reporter to process its claims, and the Department insists on requiring that mandated reporter to report data obtained from voluntary reporters, Liberty Mutual is subject to regulation through the Department's regulation of BCBSMA.

An injury-in-fact "must be actual or imminent to ensure that the court avoids deciding a purely hypothetical case in which the projected harm may ultimately fail to occur." *Baur v. Veneman,* 352 F.3d 625, 632 (2d Cir. 2003). "'One does not have to await the consummation of threatened injury to obtain preventive relief. If the injury is certainly impending, that is enough.'" *Babbitt v. United Farm Workers Nat'l Union,* 442 U.S. 289, 298 (1979) (quoting *Pennsylvania v. West Virginia,* 262 U.S. 553, 593 (1923)). Under the circumstances presented here, Liberty Mutual has adequately alleged injury-in-fact. *See Davis v. Fed. Election Comm'n,* 554 U.S. 724, 733 (2008) (holding that a candidate for Congressional seat had standing to challenge election law disclosure requirements due to an imminent threat that he would have to make disclosure or face enforcement action).

With respect to the second element of constitutional standing, a causal connection, there can be no serious dispute that the forced reporting of its Plan's data is "fairly traceable to the challenged action" of the Department. *Lujan,* 504 U.S. at 560. The Department argues that BCBSMA would be the cause of any alleged injury to Liberty Mutual should BCBSMA comply with the subpoena, and that Liberty Mutual's injury is therefore caused by the independent action of "a third party not before the court." Mot. to Dismiss 5 (citing *Lujan,* 504 U.S. at 560). The Department fails to acknowledge that BCBSMA would not be inflicting an alleged injury upon Liberty Mutual were it not for the Department's subpoena and threatened

enforcement. The Department's actions need not be "the very last step in the chain of causation," *Bennett v. Spear*, 520 U.S. 154, 169 (1997); it will suffice if Liberty Mutual's injury is produced by the Department's "coercive effect upon the action of someone else," *id.*, in this case BCBSMA.

The Department suggests – although it has not briefed the issue – that Liberty Mutual also cannot satisfy the redressability element of constitutional standing. Mot. to Dismiss 6. On the contrary, a favorable decision from this Court would allow Liberty Mutual to avoid providing its health care data to the Department, exactly the harm of which Liberty Mutual complains. *See Sprint Commc'ns Co., L.P. v. APCC Servs., Inc.*, 554 U.S. 269, 287 (2008) (reiterating that the redressability inquiry focuses on whether the particular injury alleged is likely to be redressed through the litigation).

Liberty Mutual has adequately alleged constitutional standing.

II. Preemption

Both parties seek summary judgment on the claim that ERISA preempts section 9410 and its accompanying regulation. Summary judgment is appropriate if the moving party "shows that there is no genuine dispute as to any material fact and [it] is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a).

> Under Rule 56[(a)] the moving party has the burden of showing the absence of any genuine issue of material fact. A fact is material when its resolution would affect the outcome of the suit under the governing law, and a dispute about a material fact is genuine if the evidence is such that a reasonable jury could return a verdict for the nonmoving party.

Gen. Elec. Co. v. New York State Dep't of Labor, 936 F.3d 1448, 1452 (2d Cir. 1991) (citations and quotation marks omitted). "Where . . . there are cross-motions for summary judgment, each party's motion must be examined on its own merits, and in each case all reasonable inferences must be drawn against the party whose motion is under consideration." *Lumbermens Mut. Cas. Co. v. RGIS Inventory Specialists, LLC*, 628 F.3d 46, 51 (2d Cir. 2010) (quotation marks and citation omitted).

The parties do not dispute that ERISA regulates Liberty Mutual's Plan. *See N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995) ("ERISA's comprehensive regulation of employee welfare and pension benefit plans extends to those that provide 'medical, surgical, or hospital care or benefits' for plan participants or their beneficiaries 'through the purchase of insurance or otherwise.'") (quoting 29 U.S.C. § 1002(1)); *see also Boggs v. Boggs*, 520 U.S. 833, 839, 841 (1997) ("ERISA is designed to ensure the proper administration of pension and welfare plans. . . . All employee

benefit plans must conform to various reporting, disclosure, and fiduciary requirements.").

ERISA Section 514(a) provides that, subject to certain exceptions, the provisions of Title I and Title IV of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" described in section 4(a) and not exempt under section 4(b) of ERISA. 29 U.S.C. § 1144(a). State law "includes all laws, decisions, rules, regulations or other State action having the effect of law." *Id.* § 1144(c)(1).

The Supreme Court originally gave this express preemption provision sweeping scope. In *Shaw v. Delta Air Lines, Inc.*, the Court stated "[t]he breadth of § 514(a)'s pre-emptive reach is apparent from that section's language." 463 U.S. 85, 96 (1983). It held that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Id.* at 96-97.

By the mid-1990's, however, the Court found ERISA's broad language "opaque," *De Buono v. NYSA-ILA Med. & Clinical Serv. Fund*, 520 U.S. 806, 809 (1997), and "unhelpful," *Travelers*, 514 U.S. at 656, remarking that "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for really, universally, relations stop nowhere." *Id.* at 655; *accord Calif. Div. of Labor Standards Enforcement v. Dillingham Const., N.A., Inc.*, 519 U.S. 316, 335 (1997) (Scalia, J. concurring)

("since . . . everything is related to everything else", suggesting that applying "relate to" literally had failed).

In *Travelers,* the Court placed ERISA preemption on the same footing as its other preemption cases, beginning with the presumption that Congress does not intend to supplant state law, particularly in areas of traditional state regulation. 514 U.S. at 654-55. Nevertheless, the Court has continued to adhere to *Shaw*'s two-pronged test for determining whether a state law relates to an employee benefit plan: "A law 'relates to' an employee benefit plan . . . if it has a connection with or reference to such a plan." *Shaw,* 463 U.S. at 96-97. Because the meaning of "relate to" is open to interpretation, "sensible construction of ERISA . . . requires [a court to] measure these words in context." *UNUM Life Ins. Co. of Am. v. Ward,* 526 U.S. 358, 363 (1999). Thus in this Circuit courts, following *Travelers,* consider that "two kinds of state laws relate to ERISA for purposes of preemption: 'those that mandate employee benefit structures or their administration, and those that provide alternative enforcement mechanisms.'" *HMI Mech. Sys., Inc. v. McGowan,* 266 F.3d 142, 149 (2d Cir. 2001) (quoting *Burgio & Campofelice, Inc. v. N.Y. State Dep't of Labor,* 107 F.3d 1000, 1008 (2d Cir. 1997)).

A. The Presumption Against Preemption

"[T]he regulation of health and safety matters is primarily, and historically, a matter of local concern."

Hillsborough County, Fla. v. Automated Med. Labs., Inc., 471 U.S. 707, 719 (1985); *accord Travelers*, 514 U.S. at 661-62; *see also Florida v. U.S. Dept. of Health & Human Servs.*, 648 F.3d 1235, 1305 (11th Cir. 2011) ("The health care industry . . . falls within the sphere of traditional state regulation."), *aff'd in part, rev'd in part sub nom. Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012). Vermont's health care database was established to further the State's policy "to ensure that all residents have access to quality health services at costs that are affordable." Vt. Stat. Ann. tit. 18, § 9401(a). Among the specific duties that the database is designed to assist with are "comparing costs between various treatment settings and approaches" and "improving the quality and affordability of patient health care and health care coverage." §§ 9410(a)(1)(D), (F).

A statute that operates in the health care field will receive the benefit of the presumption against preemption, even if it does not directly regulate health care providers or services. For example, in 1997 the Supreme Court considered whether a New York statute that imposed a tax on gross receipts for patient services was preempted as applied to medical centers operated by ERISA plans. *DeBuono*, 520 U.S. at 809. The Court acknowledged that the law was a revenue-raising measure rather than a regulation of hospitals; nevertheless it applied the presumption against preemption because the statute "clearly operates in a field that has been traditionally occupied by the States." *Id.* at 814 (internal quotation

marks and citation omitted). The Court distinguished the statute at issue from types of state law that Congress intended ERISA to preempt: laws that forbid a method of calculating pension benefits, or require the provision of certain benefits; state-law causes of action in which the existence of a pension plan is a critical element; laws that expressly refer to ERISA or ERISA plans. *Id.* at 814-15. It observed that "[a]ny state . . . law[ ] that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute," *id.* at 816, and held that New York could collect its tax. *Id.* at 809.

That Congress also regulates in the field of health care or health information technology, *see* HIPAA, Pub. L. No. 104-191, 110 Stat. 1936 (1996), for example, doesn't disturb the presumption against preemption for a state law that operates in the field of health care. Nevertheless, the presumption against preemption "can be overcome where . . . Congress has made clear its desire for pre-emption." *Egelhoff v. Egelhoff*, 532 U.S. 141, 151 (2001).

B. Reference to ERISA Plans

"Where a State's law acts immediately and exclusively upon ERISA plans, . . . or where the existence of ERISA plans is essential to the law's operation, . . . that 'reference' will result in pre-emption."

Dillingham, 519 U.S. at 325. "'State laws which are specifically designed to affect employee benefit plans are preempted.'" *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990) (quoting *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 829 (1988)).

Liberty Mutual asserts that the regulation expressly mentions self-funded ERISA plans, and requires such plans to report their data.[3] That is certainly true. But "'[t]he Supreme Court has never found a statute to be preempted simply because the word ERISA (or its equivalent) appears in the text.'" *Romney v. Lin*, 94 F.3d 74, 79 (2d Cir. 1996) (quoting *NYS Health Maint. Org. Conference v. Curiale*, 64 F.3d 794, 800 (2d Cir. 1995)); *accord Hattem v. Schwarzenegger*, 449 F.3d 423, 432 (2d Cir. 2006) ("While singling out ERISA plans for special treatment is considered a 'reference,' simply mentioning the word 'ERISA' is not.").[4]

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[3] Section 3X includes in its definition of "health insurer," "to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities." Reg. H-2008-01, § 3X. Health insurers, with the exception of voluntary reporters, must submit medical claims data, pharmacy claims data, member eligibility data, provider data, and other information relating to health care. . . ." *Id.* § 4D, E.

[4] The contrary is also true of course. A statute may "refer" to ERISA plans and therefore be preempted without actually using the phrase. *See Romney*, 94 F.3d at 78 (citing cases).

In *Curiale,* a Second Circuit panel held that a state regulation that established health insurance pools to equalize the risk of high-cost claims or persons did not refer to an ERISA plan. Even though the regulation "implicate [d]" ERISA plans, its "allusion" to ERISA was "not tantamount to a reference because the regulation [could] be applied without guidance from or interference with an ERISA plan." *Id.* at 801. The calculation of an insurer's pool contributions or reimbursements was unaffected by the presence or absence of an ERISA plan in the pool, because the contributions or reimbursements were based upon the insurer's membership, not on the benefits provided to the members. And the regulation did not require any changes to the contents of the benefits package. *Id.*

In a challenge to Maine's Unfair Prescription Drug Practices Act, a First Circuit panel found no ERISA preemption. *See Pharm. Care Mgmt. Ass'n v. Rowe,* 429 F.3d 294, 299 (1st Cir. 2005), *cert. denied,* 547 U.S. 1179 (2006). Relying upon *Dillingham,* and its own precedents, it emphasized that the existence of ERISA plans was not essential to the operation of the statute, and that the statute applies to a broad spectrum of health care institutions and health benefit providers. *Id.* at 303. "'[A] state law that applies to a wide variety of situations, including an appreciable number that have no specific linkage to ERISA plans, constitutes a law of general application for purposes of 29 U.S.C. § 1144.'" *Id.* at 304 (quoting

Carpenters Local Union No. 26 v. United States Fid. & Guar. Co., 215 F.3d 136, 144-45 (1st Cir. 2000)).

Vermont's statute and regulation do not act immediately and exclusively upon ERISA plans, nor is the existence of ERISA plans essential to their operation. Self-insured plans and their TPAs are only two of several entities that the statute and regulation cover. The Department affirms that VHCURES data includes information provided by BCBSMA from other self-funded plans, as well as from members not affiliated with an ERISA plan. *See* Aff. of Dian Kahn ¶¶ 5-6, ECF No. 48-1. VHCURES also requires data from hospitals, health insurance companies, managed care organizations and pharmacy benefit managers among others. *See* § 9410(c); Reg. H-2008-01 § 3X.

Vermont's statute and regulation, which "'function[ ] irrespective of . . . the existence of an ERISA plan,'" *Dillingham*, 519 U.S. at 328 (quoting *Ingersoll-Rand Co.*, 498 U.S. at 139), do not make reference to ERISA plans as that term is understood by the United States Supreme Court and the Second Circuit. *See, e.g., Dillingham*, 519 U.S. at 328; *Hattem*, 449 F.3d at 435.

C. Connection with ERISA Plans

To determine whether a state law has a connection with ERISA plans, the Court "look[s] to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive," *Travelers*, 514 U.S. at 656, "as well as

to the nature of the effect of the state law on ERISA plans." *Dillingham,* 519 U.S. at 325. The Supreme Court "ha[s] cautioned against an uncritical literalism that would make pre-emption turn on infinite connections," *Egelhoff,* 532 U.S. at 147 (internal quotation marks and citation omitted); yet if a statute "implicates an area of core ERISA concern," it will have an impermissible connection with ERISA plans. *Id.*

In *Gerosa v. Savasta & Co.,* 329 F.3d 317, 324 (2d Cir. 2003), the appeals court surveyed lower court opinions attempting to apply the Supreme Court's ERISA preemption principles, and identified "several clear trends." One, courts' preemption analyses have focused "on the core ERISA entities: beneficiaries, participants, administrators, employers, trustees and other fiduciaries, and the plan itself. Courts are reluctant to find that Congress intended to preempt state laws that do not affect the relationships among these groups." *Id.* Two, "state laws that would tend to control or supersede central ERISA functions – such as state laws affecting the determination of eligibility for benefits, amounts of benefits, or means of securing unpaid benefits – have typically been found to be preempted." *Id.*; *accord Stevenson v. Bank of N.Y. Co.,* 609 F.3d 56, 59 (2d Cir. 2010); *see also Pharm. Care Mgmt. Ass'n v. Dist. of Columbia,* 613 F.3d 179, 184 (D.C. Cir. 2010) ("The administration of employee benefits clearly is an area of core ERISA concern, [and o]ne of the principal goals of ERISA is to enable employers to establish a uniform administrative

scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits.") (internal quotation marks and citation omitted); *Gen. Elec. Co.*, 891 F.2d at 29 (A state law has a connection with ERISA plans where it "prescribes either the type and amount of an employer's contributions to a plan, the rules and regulations under which the plan operates, or the nature and amount of the benefits provided thereunder.") (citations omitted); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 146-47 (2d Cir. 1989) ("What triggers ERISA preemption is not just any indirect effect on administrative procedures but rather an effect on the primary administrative functions of benefit plans, such as determining an employee's eligibility for a benefit and the amount of that benefit."); *accord Howard v. Gleason Corp.*, 901 F.2d 1154, 1157 (2d Cir. 1990).

In *Hattem*, the appeals court took a close look at *Travelers*, noting that "preemption is not called for 'if the state law has only a tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability.'" 449 F.3d at 429 (quoting *Travelers*, 514 U.S. at 661). An indirect economic effect on choices that a plan administrator must make is insufficient; "rather, the law must actually dictate which choices *must* be made." *Id.* A state law's indirect economic effect may, however, be so "acute" "'as to force an ERISA plan to adopt a certain scheme,' which might result in preemption." *Id.* (quoting *Travelers*, 514 U.S. at 668).

Hattem also discussed the Supreme Court's decision in *Egelhoff,* in which the Court found that a state law did have an impermissible connection with an employee benefit plan. 532 U.S. at 147. The Washington statute at issue automatically revoked upon divorce an individual's beneficiary designation on any nonprobate asset. This law "interfered with a nationally uniform plan administration, the creation of which was another goal of ERISA." 449 F.3d at 430 (citing *Egelhoff,* 532 U.S. at 148-50). Were a similar law adopted in every state, a plan administrator would have to research every state's law each time it needed to pay the beneficiary of a plan participant. *Id.*

Vermont's statute and regulation does not require any particular health plan or benefit structure, or specific benefits or enforcement mechanism. It does not alter the procedures by which Liberty Mutual processes claims and disburses benefits. There is no evidence that the law affects the relationships among core ERISA entities or creates an economic effect so acute as to dictate certain administrative choices.[5]

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[5] Vermont's law does not in fact require Liberty Mutual to do anything at all. BCBSMA bears the burden of compliance, if there is one. There is no evidence that BCBSMA is laboring under any sort of burden. Although Liberty Mutual has argued with fervor that the reporting obligations are "onerous," "staggering," "extensive and arcane, and a distraction from plan administration," Mem. in Supp. of Mot. for Summ. J. 17, ECF No. 35-1, citing the length and detail of the regulation itself and the Department's reference manual for companies subject to the

(Continued on following page)

Nevertheless, Liberty Mutual stresses the Supreme Court's commentary that the purpose of ERISA's preemption provision was "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government." *Ingersoll-Rand,* 498 U.S. at 143; *accord Burgio & Campofelice, Inc. v. New York State Dep't of Labor,* 107 F.3d 1000, 1007-08 (2d Cir. 1997); *see also Travelers,* 514 U.S. at 657 (describing the objective of ERISA preemption "as being to 'eliminate[e] [sic] the threat of conflicting and inconsistent State and local regulation.'" (quoting Representative John Dent, a sponsor of the legislation)). The Supreme Court has generalized on more than one occasion that Section 514(a) preempts "state laws dealing with the subject matters covered by ERISA," including reporting and disclosure. *Shaw,* 463 U.S. at 98; *accord Travelers,* 514 U.S. at 661; *FMC Corp. v. Holliday,* 498 U.S. 52, 58-59 (1990). Thus, in Liberty Mutual's view ERISA preempts any state law that imposes a reporting requirement on an ERISA plan, regardless of the purpose for the data, the type of data required, or the law's effect if any on

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regulation, it has not submitted any information about any actual burden suffered by itself or BCBSMA in producing this information. BCBSMA apparently provides the data without protest on behalf of other self-funded plans. *See* Kahn Aff. ¶¶ 5-6.

core ERISA entities, their functions or their relationships. Liberty Mutual draws support for this position from ERISA's legislative history and the fate of Hawaii's Prepaid Health Care Act, passed in 1974.[6]

Upon examining ERISA's legislative history, the Supreme Court stated that the scope of ERISA's preemption provision is "as broad as its language." *Shaw,* 463 U.S. at 98; *accord FMC Corp.,* 498 U.S. at 59. Yet it also warned against an "uncritical literalism," *Egelhoff,* 532 U.S. at 147, and stressed that parties' contentions about the scope of ERISA preemption must be viewed in context. *See Boggs v. Boggs,* 520 U.S. at 845. Thus the Court has consistently emphasized that "the principal object of the statute is to protect plan participants and beneficiaries." *Id.*; *see also Dillingham,* 519 U.S. at 326-27 ("'In enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds. *To that end,* it

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[6] Also in 1974, the year ERISA was enacted with its express preemption clause, Congress enacted the National Health Planning and Resources Development Act of 1974 ("NHPRDA"), Pub. L. No. 93-641, 88 Stat. 2225. Among other things, this law required states to create health planning agencies which would, among other things, be responsible for the gathering and analysis of data relevant to the costs of medical services. *See Travelers,* 514 U.S. at 665. Following Liberty Mutual's reasoning that any reporting requirement that affects an ERISA plan is preempted, Congress would have precluded the states' gathering of cost information from ERISA plans even as Congress was authorizing such activity with the NHPRDA.

established extensive reporting, disclosure, and fiduciary duty requirements to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator.'") (quoting *Massachusetts v. Morash*, 490 U.S. 107, 115 (1989) (emphasis supplied)); *Travelers*, 514 U.S. at 651 (ERISA "protect[s] plan participants and their beneficiaries by . . . control[ling] the administration of benefit plans . . . as by imposing reporting and disclosure mandates. . . .").

If "[t]he focus of [ERISA] . . . is on the administrative integrity of benefit plans," *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 15 (1987), it is to assure uniformity of regulation with respect to the *activities* and *operations* of such plans. *Id.* at 15-16 (citing and quoting from the legislative history). The appropriate question therefore is not the uncritically literal one of whether Vermont's health care database law imposes a reporting requirement on the TPA of an ERISA plan. It is rather a more contextual one: whether a state data reporting requirement dictates or disrupts the activities or operations of an ERISA plan, or compromises the administrative integrity of an ERISA plan, or in some way creates state oversight of the administration of an ERISA plan.

For example, the case cited by Liberty Mutual as a paradigm of ERISA preemption was a challenge to Hawaii's Prepaid Health Care Act. The Act included reporting and disclosure requirements along with its imperative to private employers to establish health care benefit plans. In *Standard Oil Co. of California*

v. Agsalud, 633 F.2d 760, 763 (9th Cir. 1980), the Ninth Circuit struck down the statute. Its reporting, disclosure and fiduciary requirements fell, without discussion, along with the benefits requirement. *Id.* at 765-66, *aff'd mem.,* 454 U.S. 801 (1981).[7]

The Hawaii statute was preempted because it required the establishment of ERISA plans or dictated the terms of existing plans, and gave the state oversight over ERISA plans' operations. *See Golden Gate Restaurant Ass'n v. City & County of San Francisco,* 546 F.3d 639, 655 (9th Cir. 2008) (describing *Agsalud* as holding that "the Hawaii statute was preempted because it required employers to have health plans, and it dictated the specific benefits employers were to provide through those plans"), *cert. denied,* 130 S. Ct. 3497 (2010); *see also Fort Halifax,* 482 U.S. at 12-13 (describing the Hawaii statute as preempted because it required the establishment of a health care plan or required existing plans to pay certain benefits).

Vermont's statute and regulation, which have nothing to do with mandating employee benefit plans or benefits and do not attempt any sort of oversight over compliance, bear no resemblance to Hawaii's

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[7] In 1983 Congress amended ERISA to specifically exempt from preemption certain provisions of the Hawaii statute that predated ERISA. *See* 29 U.S.C. § 1144(b)(5). The exempted provisions did not include the reporting or disclosure requirements, which remained preempted by the *Agsalud* ruling. *See Fort Halifax,* 482 U.S. at 13 n.7.

Prepaid Health Care Act, and "create[] no impediment to an employer's adoption of a uniform benefit administration scheme." *Id.* at 14 (holding that a Maine statute requiring a one-time severance payment to employees in the event of a plant closing was not preempted because it did not mandate a benefit plan or require the establishment of a scheme to administer benefits, or change or alter its ability to operate its plan).

The Second Circuit Court of Appeals' opinion in *HMI Mechanical Systems* further illustrates the distinction between a state law that requires ERISA plans to provide specific benefits or follow certain eligibility criteria and a state law that seeks information held by plans. New York law requires businesses who perform public work projects to pay their employees the locally prevailing wage amount, which encompasses not only cash wages but non-cash benefits such as health, retirement and disability benefits. A business may comply with the law by contributing to an ERISA plan on behalf of its employees. HMI, as a business subject to the law, refused to comply with the state's demands for information about HMI's contributions to its ERISA plans. It sought a declaration that ERISA preempted the state's investigation into its allocation of benefits, contending that the state sought to regulate the administration of an ERISA plan. The district and appeals courts disagreed, concluding that the state was not mandating a particular benefit structure or requiring particular contributions. 266 F.3d at 151. It held only that the

state could not delve into the internal allocations of benefits within the plan. *Id.* at 151-52.

The Department's efforts to enforce its health care database statute and regulation do not seek to regulate the administration of Liberty Mutual's Plan, or its allocation of benefits. Providing the information requested may create some degree of administrative burden for the TPA and by extension Liberty Mutual; such an effect, peripheral to the core ERISA functions and relationships, does not warrant preemption.

Conclusion

Section 9410 and its accompanying regulation is a law of general applicability concerning an area of traditional state police power. The law applies to a broad range of entities, including health care providers, health care facilities and health insurers. § 9410(c). It is not directed at any particular plans, or types of plans, or employee benefit plans in general. The State's intention is to improve the administration of health care services, and it has determined that it is in need of better health care data to ensure the delivery of quality health services at an affordable cost. Plans such as Liberty Mutual's have data that can assist the achievement of that goal. Compliance with the reporting requirements of H-2008-1 may have some indirect effect on health benefit plans, but that effect is so peripheral that the regulation cannot be considered an attempt to interfere with the administration or structure of a welfare benefit plan. *See*

De Buono, 520 U.S. at 815-16 (concluding that a state statute that imposes some administrative burden on an ERISA plan is not automatically preempted).

"[I]n the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Pegram v. Herdrich,* 530 U.S. 211, 237 (2000). Liberty Mutual has not overcome the presumption against preemption. The law does not make reference to ERISA plans, as that term has been construed in the case law, and makes no attempt to control, supersede or interfere with the operation of an ERISA plan. In short, because the law's reporting requirement has no effect whatsoever on the core relationships that ERISA was designed to protect – those between participants, beneficiaries, administrators and employers – and no effect whatsoever on the core ERISA functions – such as processing claims or disbursing benefits – "it poses no danger of undermining the uniformity of the administration of benefits that is ERISA's key concern." *Stevenson,* 609 F.3d at 61. "[P]reemption of [Vermont's] law would not serve the purpose for which ERISA's preemption provision was enacted." *Fort Halifax,* 482 U.S. at 14-15. Liberty Mutual's motion for summary judgment is therefore **denied**. The Department's motion to dismiss is **denied** with respect to standing and **granted** with respect to preemption.

CASE CLOSED.

Dated at Burlington, in the District of Vermont, this 9th day of November, 2012.

/s/ William K. Sessions III
William K. Sessions III
District Court Judge

UNITED STATES COURT OF APPEALS
FOR THE
SECOND CIRCUIT

At a stated term of the United States Court of Appeals for the Second Circuit, held at the Thurgood Marshall United States Courthouse, 40 Foley Square, in the City of New York, on the 16th day of May, two thousand fourteen,

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Liberty Mutual
Insurance Company,

Plaintiff-Appellant,

v.

Susan L. Donegan, in her capacity as the Commissioner of the Vermont Department of Financial Regulation,

Defendant-Appellee.

ORDER

Docket No: 12-4881

Appellee Susan L. Donegan filed a petition for panel rehearing, or, in the alternative, for rehearing *en banc*. The panel that determined the appeal has considered the request for panel rehearing, and the active members of the Court have considered the request for rehearing *en banc*.

IT IS HEREBY ORDERED that the petition is denied.

FOR THE COURT:
Catherine O'Hagan Wolfe,
Clerk

[SEAL]

/s/ Catherine O'Hagan Wolfe

United States Code
Title 29. Labor
Chapter 18. Employee Retirement
Income Security Program

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company

or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw.Rev.Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section –

> **(i)** any State tax law relating to employee benefit plans, or
>
> **(ii)** any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall

supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

(6)(A) Notwithstanding any other provision of this section –

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides –

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may

apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) of this section shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title), qualified medical child support orders (within the meaning of section 1169(a)(2)(A) of this title), and the provisions of law referred to in section 1169(a)(2)(B)(ii) of this title to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action –

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.] which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 1191 of this title.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the

United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

(e)(1) Notwithstanding any other provision of this section, this subchapter shall supersede any law of a State which would directly or indirectly prohibit or restrict the inclusion in any plan of an automatic contribution arrangement. The Secretary may prescribe regulations which would establish minimum standards that such an arrangement would be required to satisfy in order for this subsection to apply in the case of such arrangement.

(2) For purposes of this subsection, the term "automatic contribution arrangement" means an arrangement –

(A) under which a participant may elect to have the plan sponsor make payments as contributions under the plan on behalf of the participant, or to the participant directly in cash,

(B) under which a participant is treated as having elected to have the plan sponsor make such contributions in an amount equal to a uniform percentage of compensation provided under the plan until the participant specifically elects not to have such contributions made (or specifically elects to have such contributions made at a different percentage), and

(C) under which such contributions are invested in accordance with regulations prescribed by the Secretary under section 1104(c)(5) of this title.

(3)(A) The plan administrator of an automatic contribution arrangement shall, within a reasonable period before such plan year, provide to each participant to whom the arrangement applies for such plan year notice of the participant's rights and obligations under the arrangement which –

(i) is sufficiently accurate and comprehensive to apprise the participant of such rights and obligations, and

(ii) is written in a manner calculated to be understood by the average participant to whom the arrangement applies.

(B) A notice shall not be treated as meeting the requirements of subparagraph (a) with respect to a participant unless –

(i) the notice includes an explanation of the participant's right under the arrangement not to have elective contributions made on the participant's behalf (or to elect to have such contributions made at a different percentage),

(ii) the participant has a reasonable period of time, after receipt of the notice described in clause (i) and before the first elective contribution is made, to make such election, and

(iii) the notice explains how contributions made under the arrangement will be invested in the absence of any investment election by the participant.

Vermont Statutes Annotated
Title Eighteen. Health
Chapter 221. Health Care Administration
Subchapter 1. Health Information Technology
§ 9401. Policy

(a) It is the policy of the state of Vermont that health care is a public good for all Vermonters and to ensure that all residents have access to quality health services at costs that are affordable. To achieve this policy, it is necessary that the state ensure the quality of health care services provided in Vermont and, until health care systems are successful in controlling their costs and resources, to oversee cost containment.

(b) It is further the policy of the state of Vermont that the health care system should:

(1) Maintain and improve the quality of health care services offered to Vermonters.

(2) Utilize planning, market, and other mechanisms that contain or reduce increases in the cost of delivering services so that health care costs do not consume a disproportionate share of Vermonters' incomes or the moneys available for other services required to insure the health, safety, and welfare of Vermonters.

(3) Encourage regional and local participation in decisions about health care delivery, financing, and provider supply.

(4) Utilize planning, market, and other mechanisms that will achieve rational allocation of health care resources in the state.

(5) Facilitate universal access to preventive and medically necessary health care.

(6) Support efforts to integrate mental health and substance abuse services with overall medical care.

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§ 9410. Health care database

(a)(1) The Board shall establish and maintain a unified health care database to enable the Commissioner and the Board to carry out their duties under this chapter, chapter 220 of this title, and Title 8, including:

(A) determining the capacity and distribution of existing resources;

(B) identifying health care needs and informing health care policy;

(C) evaluating the effectiveness of intervention programs on improving patient outcomes;

(D) comparing costs between various treatment settings and approaches;

(E) providing information to consumers and purchasers of health care; and

(F) improving the quality and affordability of patient health care and health care coverage.

(2)(A) The program authorized by this section shall include a consumer health care price and quality information system designed to make available to consumers transparent health care price information, quality information, and such other information as the Board determines is necessary to empower individuals, including uninsured individuals, to make economically sound and medically appropriate decisions.

(B) The Commissioner may require a health insurer covering at least five percent of the lives covered in the insured market in this State to file with the Commissioner a consumer health care price and quality information plan in accordance with rules adopted by the Commissioner.

(C) The Board shall adopt such rules as are necessary to carry out the purposes of this subdivision. The Board's rules may permit the gradual implementation of the consumer health care price and quality information system over time, beginning with health care price and quality information that the Board determines is most needed by consumers or that can be most practically provided to the consumer in an understandable manner. The rules shall permit health insurers to use security measures designed to allow subscribers access to price and other information without disclosing trade secrets to individuals and entities who are not subscribers. The rules shall avoid unnecessary duplication of efforts relating to price and quality reporting by health insurers, health care providers, health care facilities, and others, including activities

undertaken by hospitals pursuant to their community report obligations under section 9405b of this title.

(b) The database shall contain unique patient and provider identifiers and a uniform coding system, and shall reflect all health care utilization, costs, and resources in this State, and health care utilization and costs for services provided to Vermont residents in another state.

(c) Health insurers, health care providers, health care facilities, and governmental agencies shall file reports, data, schedules, statistics, or other information determined by the Board to be necessary to carry out the purposes of this section. Such information may include:

(1) health insurance claims and enrollment information used by health insurers;

(2) information relating to hospitals filed under subchapter 7 of this chapter (hospital budget reviews); and

(3) any other information relating to health care costs, prices, quality, utilization, or resources required by the Board to be filed.

(d) The Board may by rule establish the types of information to be filed under this section, and the time and place and the manner in which such information shall be filed.

(e) Records or information protected by the provisions of the physician-patient privilege under 12

V.S.A. § 1612(a), or otherwise required by law to be held confidential, shall be filed in a manner that does not disclose the identity of the protected person.

(f) The Board shall adopt a confidentiality code to ensure that information obtained under this section is handled in an ethical manner.

(g) Any person who knowingly fails to comply with the requirements of this section or rules adopted pursuant to this section shall be subject to an administrative penalty of not more than $1,000.00 per violation. The Board may impose an administrative penalty of not more than $10,000.00 each for those violations the Board finds were willful. In addition, any person who knowingly fails to comply with the confidentiality requirements of this section or confidentiality rules adopted pursuant to this section and uses, sells, or transfers the data or information for commercial advantage, pecuniary gain, personal gain, or malicious harm shall be subject to an administrative penalty of not more than $50,000.00 per violation. The powers vested in the Board by this subsection shall be in addition to any other powers to enforce any penalties, fines, or forfeitures authorized by law.

(h)(1) All health insurers shall electronically provide to the Board in accordance with standards and procedures adopted by the Board by rule:

(A) their health insurance claims data, provided that the Board may exempt from all or a portion of the filing requirements of this subsection data

reflecting utilization and costs for services provided in this State to residents of other states;

(B) cross-matched claims data on requested members, subscribers, or policyholders; and

(C) member, subscriber, or policyholder information necessary to determine third party liability for benefits provided.

(2) The collection, storage, and release of health care data and statistical information that is subject to the federal requirements of the Health Insurance Portability and Accountability Act ("HIPAA") shall be governed exclusively by the regulations adopted thereunder in 45 C.F.R. Parts 160 and 164.

(A) All health insurers that collect the Health Employer Data and Information Set (HEDIS) shall annually submit the HEDIS information to the Board in a form and in a manner prescribed by the Board.

(B) All health insurers shall accept electronic claims submitted in Centers for Medicare and Medicaid Services format for UB-92 or HCFA-1500 records, or as amended by the Centers for Medicare and Medicaid Services.

(3)(A) The Board shall collaborate with the Agency of Human Services and participants in the Agency's initiatives in the development of a comprehensive health care information system. The collaboration is intended to address the formulation of a description of the data sets that will be included in the comprehensive health care information system, the criteria

and procedures for the development of limited-use data sets, the criteria and procedures to ensure that HIPAA compliant limited-use data sets are accessible, and a proposed time frame for the creation of a comprehensive health care information system.

(B) To the extent allowed by HIPAA, the data shall be available as a resource for insurers, employers, providers, purchasers of health care, and State agencies to continuously review health care utilization, expenditures, and performance in Vermont. In presenting data for public access, comparative considerations shall be made regarding geography, demographics, general economic factors, and institutional size.

(C) Consistent with the dictates of HIPAA, and subject to such terms and conditions as the Board may prescribe by rule, the Vermont Program for Quality in Health Care shall have access to the unified health care database for use in improving the quality of health care services in Vermont. In using the database, the Vermont Program for Quality in Health Care shall agree to abide by the rules and procedures established by the Board for access to the data. The Board's rules may limit access to the database to limited-use sets of data as necessary to carry out the purposes of this section.

(D) Notwithstanding HIPAA or any other provision of law, the comprehensive health care information system shall not publicly disclose any data that contains direct personal identifiers. For the purposes of this section, "direct personal identifiers" include information relating to an

individual that contains primary or obvious identifiers, such as the individual's name, street address, e-mail address, telephone number, and Social Security number.

(i) On or before January 15, 2008 and every three years thereafter, the Commissioner shall submit a recommendation to the General Assembly for conducting a survey of the health insurance status of Vermont residents.

(j)(1) As used in this section, and without limiting the meaning of subdivision 9402(8) of this title, the term "health insurer" includes:

(A) any entity defined in subdivision 9402(8) of this title;

(B) any third party administrator, any pharmacy benefit manager, any entity conducting administrative services for business, and any other similar entity with claims data, eligibility data, provider files, and other information relating to health care provided to a Vermont resident, and health care provided by Vermont health care providers and facilities required to be filed by a health insurer under this section;

(C) any health benefit plan offered or administered by or on behalf of the State of Vermont or an agency or instrumentality of the State; and

(D) any health benefit plan offered or administered by or on behalf of the federal government with the agreement of the federal government.

(2) The Board may adopt rules to carry out the provisions of this subsection, including criteria for the required filing of such claims data, eligibility data, provider files, and other information as the Board determines to be necessary to carry out the purposes of this section and this chapter.

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§ 9410. Health care database [Prior to 2013 Amendment]

(a)(1) The commissioner shall establish and maintain a unified health care data base to enable the commissioner to carry out the duties under this chapter and Title 8, including:

(A) Determining the capacity and distribution of existing resources.

(B) Identifying health care needs and informing health care policy.

(C) Evaluating the effectiveness of intervention programs on improving patient outcomes.

(D) Comparing costs between various treatment settings and approaches.

(E) Providing information to consumers and purchasers of health care.

(F) Improving the quality and affordability of patient health care and health care coverage.

(2)(A) The program authorized by this section shall include a consumer health care price and quality information system designed to make available to consumers transparent health care price information, quality information, and such other information as the commissioner determines is necessary to empower individuals, including uninsured individuals, to make economically sound and medically appropriate decisions.

(B) The commissioner shall convene a working group composed of the commissioner of mental health, the commissioner of Vermont health access, health care consumers, the office of the health care ombudsman, employers and other payers, health care providers and facilities, the Vermont program for quality in health care, health insurers, and any other individual or group appointed by the commissioner to advise the commissioner on the development and implementation of the consumer health care price and quality information system.

(C) The commissioner may require a health insurer covering at least five percent of the lives covered in the insured market in this state to file with the commissioner a consumer health care price and quality information plan in accordance with rules adopted by the commissioner.

(D) The commissioner shall adopt such rules as are necessary to carry out the purposes of this subdivision. The commissioner's rules may permit the gradual implementation of the consumer health care price

and quality information system over time, beginning with health care price and quality information that the commissioner determines is most needed by consumers or that can be most practically provided to the consumer in an understandable manner. The rules shall permit health insurers to use security measures designed to allow subscribers access to price and other information without disclosing trade secrets to individuals and entities who are not subscribers. The regulations shall avoid unnecessary duplication of efforts relating to price and quality reporting by health insurers, health care providers, health care facilities, and others, including activities undertaken by hospitals pursuant to their community report obligations under section 9405b of this title.

(b) The database shall contain unique patient and provider identifiers and a uniform coding system, and shall reflect all health care utilization, costs and resources in this state, and health care utilization and costs for services provided to Vermont residents in another state.

(c) Health insurers, health care providers, health care facilities, and governmental agencies shall file reports, data, schedules, statistics, or other information determined by the commissioner to be necessary to carry out the purposes of this section. Such information may include:

(1) health insurance claims and enrollment information used by health insurers;

(2) information relating to hospitals filed under subchapter 7 of this chapter (hospital budget reviews); and

(3) any other information relating to health care costs, prices, quality, utilization, or resources required to be filed by the commissioner.

(d) The commissioner may by rule establish the types of information to be filed under this section, and the time and place and the manner in which such information shall be filed.

(e) Records or information protected by the provisions of the physician-patient privilege under 12 V.S.A. § 1612(a), or otherwise required by law to be held confidential, shall be filed in a manner that does not disclose the identity of the protected person.

(f) The commissioner shall adopt a confidentiality code to ensure that information obtained under this section is handled in an ethical manner.

(g) Any person who knowingly fails to comply with the requirements of this section or rules adopted pursuant to this section shall be subject to an administrative penalty of not more than $1,000.00 per violation. The commissioner may impose an administrative penalty of not more than $10,000.00 each for those violations the commissioner finds were willful. In addition, any person who knowingly fails to comply with the confidentiality requirements of this section or confidentiality rules adopted pursuant to this

section and uses, sells, or transfers the data or information for commercial advantage, pecuniary gain, personal gain, or malicious harm shall be subject to an administrative penalty of not more than $50,000.00 per violation. The powers vested in the commissioner by this subsection shall be in addition to any other powers to enforce any penalties, fines, or forfeitures authorized by law.

(h)(1) All health insurers shall electronically provide to the commissioner in accordance with standards and procedures adopted by the commissioner by rule:

(A) their health insurance claims data, provided that the commissioner may exempt from all or a portion of the filing requirements of this subsection data reflecting utilization and costs for services provided in this state to residents of other states;

(B) cross-matched claims data on requested members, subscribers, or policyholders; and

(C) member, subscriber, or policyholder information necessary to determine third party liability for benefits provided.

(2) The collection, storage, and release of health care data and statistical information that is subject to the federal requirements of the Health Insurance Portability and Accountability Act ("HIPAA") shall be governed exclusively by the rules adopted thereunder in 45 CFR Parts 160 and 164.

(A) All health insurers that collect the Health Employer Data and Information Set (HEDIS) shall

annually submit the HEDIS information to the commissioner in a form and in a manner prescribed by the commissioner.

(B) All health insurers shall accept electronic claims submitted in Centers for Medicare and Medicaid Services format for UB-92 or HCFA-1500 records, or as amended by the Centers for Medicare and Medicaid Services.

(3)(A) The commissioner shall collaborate with the agency of human services and participants in agency of human services initiatives in the development of a comprehensive health care information system. The collaboration is intended to address the formulation of a description of the data sets that will be included in the comprehensive health care information system, the criteria and procedures for the development of limited use data sets, the criteria and procedures to ensure that HIPAA compliant limited use data sets are accessible, and a proposed time frame for the creation of a comprehensive health care information system.

(B) To the extent allowed by HIPAA, the data shall be available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in Vermont. In presenting data for public access, comparative considerations shall be made regarding geography, demographics, general economic factors, and institutional size.

(C) Consistent with the dictates of HIPAA, and subject to such terms and conditions as the commissioner may prescribe by regulation, the Vermont program for quality in health care shall have access to the unified health care database for use in improving the quality of health care services in Vermont. In using the database, the Vermont program for quality in health care shall agree to abide by the rules and procedures established by the commissioner for access to the data. The commissioner's rules may limit access to the database to limited-use sets of data as necessary to carry out the purposes of this section.

(D) Notwithstanding HIPAA or any other provision of law, the comprehensive health care information system shall not publicly disclose any data that contains direct personal identifiers. For the purposes of this section, "direct personal identifiers" include information relating to an individual that contains primary or obvious identifiers, such as the individual's name, street address, e-mail address, telephone number, and Social Security number.

(i) On or before January 15, 2008 and every three years thereafter, the commissioner shall submit a recommendation to the general assembly for conducting a survey of the health insurance status of Vermont residents.

(j)(1) As used in this section, and without limiting the meaning of subdivision 9402(8) of this title, the term "health insurer" includes:

(A) any entity defined in subdivision 9402(8) of this title;

(B) any third party administrator, any pharmacy benefit manager, any entity conducting administrative services for business, and any other similar entity with claims data, eligibility data, provider files, and other information relating to health care provided to Vermont resident, and health care provided by Vermont health care providers and facilities required to be filed by a health insurer under this section;

(C) any health benefit plan offered or administered by or on behalf of the state of Vermont or an agency or instrumentality of the state; and

(D) any health benefit plan offered or administered by or on behalf of the federal government with the agreement of the federal government.

(2) The commissioner may adopt rules to carry out the provisions of this subsection, including standards and procedures requiring the registration of persons or entities not otherwise licensed or registered by the commissioner and criteria for the required filing of such claims data, eligibility data, provider files, and other information as the commissioner determines to be necessary to carry out the purposes of this section and this chapter.

REGULATION H-2008-01

Vermont Healthcare Claims Uniform Reporting and Evaluation System ("VHCURES")

Section 1: Purpose

The purpose of this rule is to set forth the requirements for the submission of health care claims data, member eligibility data, and other information relating to health care provided to Vermont residents or by Vermont health care providers and facilities by health insurers, managed care organizations, third party administrators, pharmacy benefit managers and others to the Department of Banking, Insurance, Securities and Health Care Administration and conditions for the use and dissemination of such claims data, all as required by and consistent with the purposes of 18 V.S.A. §9410.

Section 2: Authority

This rule is issued pursuant to the authority vested in the Commissioner of the Department of Banking, Insurance, Securities and Health Care Administration by 18 V.S.A. §9410, as well as 8 V.S.A. §15 and other applicable portions of Chapter 221 of Title 18.

Section 3: Definitions As used in this Rule

A. "BISHCA" or "Department" means the Vermont Department of Banking, Insurance, Securities and Health Care Administration.

B. "Capitated services" means services rendered by a provider through a contract in which payment are based upon a fixed dollar amount for each member on a monthly basis.

C. "Cell size" means the count of persons that share a set of characteristics contained in a statistical table.

D. "Charge" means the actual dollar amount charged on the claim.

E. "Co-insurance" means the percentage a member pays toward the cost of a covered service.

F. "Commissioner" means the commissioner of the Department of Banking, Insurance, Securities and Health Care Administration or his or her designee.

G. "Co-payment" means the fixed dollar amount a member pays to a health care provider at the time a covered service is provided or the full cost of a service when that is less than the fixed dollar amount.

H. "Current Procedural Terminology (CPT)" means a medical code set of physician and other services, maintained and copyrighted by the American Medical Association (AMA), and adopted by the U.S. Secretary of Health and Human Services as the standard for reporting physician and other services on standard transactions.

I. "Data set" means a collection of individual data records, whether in electronic or manual files.

J. "Deductible" means the total dollar amount a member pays towards the cost of covered services

over an established period of time before the contracted third-party payer makes any payments.

K. "De-identified health information" means information that does not identify an individual patient, member or enrollee and with respect to which no reasonable basis exists to believe that the information can be used to identify an individual patient, member or enrollee. De-identification means that health information is not individually identifiable and requires the removal of Direct Personal Identifiers associated with patients, members or enrollees.

L. "Direct personal identifiers" is information relating to an individual patient, member or enrollee that contains primary or obvious identifiers, including:

(1) Names;

(2) Business names when that name would serve to identify a person;

(3) Postal address information other than town or city, state, and 5-digit zip code;

(4) Specific latitude and longitude or other geographic information that would be used to derive postal address;

(5) Telephone and fax numbers;

(6) Electronic mail addresses;

(7) Social security numbers;

(8) Vehicle Identifiers and serial numbers, including license plate numbers;

(9) Medical record numbers;

(10) Health plan beneficiary numbers;

(11) Certificate and license numbers;

(12) Internet protocol (IP) addresses and uniform resource locators (URL) that identify a business that would serve to identify a person;

(13) Biometric identifiers, including finger and voice prints; and

(14) Personal photographic images.

M. "Disclosure" means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

N. "Encrypted identifier" is a code or other means of record identification to allow patients, members or enrollees to be tracked across the data set without revealing their identity. Encrypted identifiers are not direct identifiers.

O. "Encryption" means a method by which the true value of data has been disguised in order to prevent the identification of persons or groups, and which does not provide the means for recovering the true value of the data.

P. "Health benefit plan" means a policy, contract, certificate or agreement entered into, or offered by a health insurer to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Q. "Healthcare claims data" means information consisting of or derived directly from member eligibility files, medical claims files, pharmacy claims files and other related data pursuant to the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) in effect at the time of the data submission. "Healthcare claims data" does not include analysis, reports, or studies containing information from health care claims data sets if those analyses, reports, or studies have already been released in response to another request for information or as part of a general distribution of public information by BISHCA.

R. "Healthcare premium" means the dollar amount charged for any policies offered by health insurers which partially or fully cover the cost of health care services.

S. "Healthcare Common Procedure Coding System (HCPCS)" means a medical code set that identifies health care procedures, equipment, and supplies for claim submission purposes. These are often known as "local codes".

T. "Health care" means care, services, or supplies related to the health of an individual. It includes but is not limited to (1) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and (2) sale or dispensing of a drug, device,

equipment, or other item in accordance with a prescription [45 CFR § 160.103].

U. "Health care facility" shall be defined as per 18 V.S.A §9432, as amended from time to time.

V. "Health care provider" means a person, partnership, corporation, facility or institution, licensed or certified or authorized by law to provide professional health care service in this state to an individual during that individual's medical care, treatment or confinement, as per 18 V.S.A. §9432.

W. "Health information" means any information, whether oral or recorded in any form or medium, that 1) is created or received by a health-care provider, health plan, public health authority, employer, life insurer, school or university, or health-care clearinghouse; and 2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual shall be as defined in 45 CFR § 160.103.

X. "Health insurer" means those entities defined in 18 V.S.A. §§ 9402 and 9410(j)(1), and includes any health insurance company, nonprofit hospital and medical service corporation, managed care organization, third party administrator, pharmacy benefit manager, and any entity conducting administrative services for business or possessing claims data, eligibility data, provider files, and other information relating to health care provided to Vermont residents or by Vermont health care providers and facilities. The

term may also include, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities.

Y. "HIPAA" means the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

Z. "Indirect personal identifiers" means information relating to an individual patient, member or enrollee that a person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods could apply to render such information individually identifiable by using such information alone or in combination with other reasonably available information.

Aa. "International Classification of Diseases" or "ICD" shall mean that medical code set maintained by the World Health Organization.

Ab. "Mandated Reporter" means a health insurer as defined herein and at 18 V.S.A. §9410(j)(1) with two hundred (200) or more enrolled or covered members in each month during a calendar year, including both Vermont residents and any non-residents receiving covered services provided by Vermont health care providers and facilities.

Ac. "Medical claims file" means a data file composed of service level remittance information for all non-denied adjudicated claims for each billed service including, but not limited to member demographics, provider information, charge/payment

information, and clinical diagnosis and procedure codes, and shall include all claims related to behavioral or mental health.

Ad. "Member" means the insured subscriber and any spouse and/or dependent covered by the subscriber's policy.

Ae. "Member eligibility file" means a data file containing demographic information for each individual member eligible for medical or pharmacy benefits for one or more days of coverage at any time during the reporting month.

Af. "Patient" means any person in the data set that is the subject of the activities of the claim performed by the health care provider.

Ag. "Payer" means a third-party payer or third-party administrator.

Ah. "Payment" means the actual dollar amount paid for a claim by a health insurer.

Ai. "Personal identifiers" means information relating to an individual that contains direct or indirect identifiers to which a reasonable basis exists to believe that the information can be used to identify an individual.

Aj. "Pharmacy Benefit Manager" or "PBM" means a person or entity that performs pharmacy benefit management as that term is defined at 18 V.S.A. §9471(4). The term includes a person or entity in a contractual or employment relationship with an entity performing pharmacy benefit management for a health plan.

Ak. "Pharmacy claims file" means a data file containing service level remittance information from all non-denied adjudicated claims for each prescription including, but not limited to: member demographics; provider information; charge/payment information; and national drug codes.

Al. "Prepaid amount" means the fee for the service equivalent that would have been paid for a specific service if the service had not been capitated.

Am. "Principal Investigator" means the person in charge of a project that makes use of limited use research health care claims data sets. The principal investigator is the custodian of the data and is responsible for compliance with all restrictions, limitations and conditions of use associated with the data release.

An. "Public Use Data Set" means a publicly available data set containing only the public use data elements specified in this Rule as unrestricted data elements in Appendix J.

Ao. "Reporter" means a health insurer as defined herein and at 18 V.S.A. §9410(j)(1), and shall include Voluntary Reporters as defined herein.

Ap. "Subscriber" means the individual responsible for payment of premiums or whose employment is the basis for eligibility for membership in a health benefit plan.

Aq. "Third-party Administrator" means any person who, on behalf of a health insurer or purchaser of health benefits, receives or collects charges, contributions or premiums for, or adjusts or settles

claims on or for residents of this State or Vermont health care providers and facilities.

Ar. "Vermont Healthcare Claims Uniform Reporting and Evaluation System" or "VHCURES" means the Department's system for the collection, management and reporting of eligibility, claims and related data submitted pursuant to 18 V.S.A. § 9410.

As. "Voluntary Reporter" includes any entity other than a mandated reporter, including any health benefit plan offered or administered by or on behalf of the federal government where such plan, with the agreement of the federal government, voluntarily submits data to the BISHCA commissioner for inclusion in the database on such terms as may be appropriate.

Section 4: Reporting Requirements

Registration and Reporting Requirements

A. VHCURES Reporter Registration. On an annual basis prior to December 31, Health Insurers shall register with the Department on a form established by the Commissioner and identify whether health care claims are being paid for members who are Vermont residents and whether health care claims are being paid for non-residents receiving covered services from Vermont health care providers or facilities. Where applicable, the completed form shall identify the types of files to be submitted per Section 5. This form shall be submitted to BISHCA or its designee. See Appendix F.

B. Third Party Administrator Registration. Any person or entity that provides third party administration services, a third party administrator or "TPA" as defined in Section 3, shall register with the Department on a form established by the Commissioner, both before doing business in Vermont and on an annual basis prior to December 31 thereafter. 18 V.S.A. §9410. See Appendix G.

C. Pharmacy Benefit Manager Registration. Any person or entity that performs pharmacy benefit management (a pharmacy benefit manager or "PBM") shall register with the Department on a form established by the Commissioner both before doing business in Vermont and on an annual basis prior to December 31. 18 V.S.A. §9421. The registration requirement includes persons or entities in a contractual or employment relationship with a health insurer or PBM performing pharmacy benefit management for a health plan with Vermont enrollees or beneficiaries. 18 V.S.A. §9471. See Appendix H.

D. Health Insurers shall regularly submit medical claims data, pharmacy claims data, member eligibility data, provider data, and other information relating to health care provided to Vermont residents and health care provided by Vermont health care providers and facilities to both Vermont residents and non-residents in specified electronic format to the Department for each health line of business (Comprehensive Major Medical, TPA/ASO, Medicare Supplemental, Medicare Part C, and Medicare Part D) per the

data submission requirements contained in the appendices to this Rule.

E. Voluntary Reporters may, with the permission of the Commissioner, participate in VHCURES and submit medical claims files, pharmacy claims files, member eligibility files, provider data, and other information relating to health care provided to Vermont residents and health care provided by Vermont health care providers and facilities to both Vermont residents and non-residents in specified electronic format to the Department per the data submission requirements contained in the appendices to this Rule.

Section 5: Required Healthcare Data Files

Mandated Reporters shall submit to BISHCA or its designee health care claims data for all members who are Vermont residents and all non-residents who received covered services provided by Vermont health care providers or facilities in accordance with the requirements of this section. Each Mandated Reporter is also responsible for the submission of all health care claims processed by any sub-contractor on its behalf unless such subcontractor is already submitting the identical data as a Mandated Reporter in its own right. The health care claims data submitted shall include, where applicable, a member eligibility file containing records associated with each of the claims files reported: a medical claims file and a pharmacy claims file. The data submitted shall also include supporting definition files for payer specific

provider specialty taxonomy codes and procedure and/or diagnosis codes.

A. General Requirements for Data Submission

(1) Adjustment Records. Adjustment records shall be reported with the appropriate positive or negative fields with the medical and pharmacy claims file submissions. Negative values shall contain the negative sign before the value. No sign shall appear before a positive value.

(2) Behavioral or Mental Health Claims. All claims related to behavioral or mental health shall be included in the medical claims file.

(3) Capitated Service Claims. Claims for capitated services shall be reported with all medical and pharmacy claims file submissions.

(4) Claims Records. Records for the medical and pharmacy claims file submissions shall be reported at the visit, service, or prescription level. The submission of the medical and pharmacy claims is based upon the paid dates and not upon the dates of service associated with the claims.

(5) Codes and Encryption Requirements

(a) Code Sources. Unless otherwise specified in this regulation, the code sources listed and described in Appendix A shall be utilized in association with the member eligibility file and medical and pharmacy claims file submissions.

(b) Member Identification Code. Reporters shall assign to each of their members a unique identification code that is the member's social security number. If a Reporter does not collect the social security numbers for all members, the Reporter shall use the social security number of the subscriber and then assign a discrete two-digit suffix for each member under the subscriber's contract.

If the subscriber's social security number is not collected by the Reporter, a version of the subscriber's certificate or contract number shall be used in its place. The discrete two-digit suffix shall also be used with the certificate or contract number. The certificate or contract number with the two-digit suffix shall be at least eleven but not more than sixty-four characters in length.

The social security number of the member/subscriber and the subscriber and member names shall be encrypted prior to submission by the Reporter utilizing a standard encryption methodology provided by BISHCA or its designee. The unique member identification code assigned by each Reporter shall remain with each member/subscriber for the entire period of coverage for that individual.

(c) Specific/Unique Coding. With the exception of provider, provider specialty, and

procedure/diagnosis codes, specific or unique coding systems shall not be permitted as part of the health care claims data set submission.

(6) Co-Insurance/Co-Payment. Co-insurance and co-payment are to be reported in two separate fields in the medical and pharmacy claims file submissions.

(7) Coordination of Benefits Claims. Claims where multiple parties have financial responsibility shall be included with all medical and pharmacy claims file submissions.

(8) Denied Claims. Denied claims shall be excluded from all medical and pharmacy claims file submissions. When a claim contains both fully processed/paid service lines and partially processed or denied service lines, only the fully processed/paid service lines shall be included as part of the health care claims data set submittal.

(9) Eligibility Records. Records for the member eligibility file submission shall be reported at the individual member level with one record submitted for each claim type. If a member is covered as both a subscriber and a dependent on two different policies during the same month, two records must be submitted. If a member has 2 contract numbers for 2 different coverage types, 2 member eligibility records shall be submitted.

(10) Exceptions.

(a) Medical Claims File Exclusions. All claims related to services provided under stand-alone health care policies shall be excluded if the services are not covered by comprehensive medical insurance policies and are provided on a stand-alone basis for:

1. Specific disease;
2. Accident:
3. Injury;
4. Hospital indemnity;
5. Disability:
6. Long-term care;
7. Student liability;
8. Vision coverage; or
9. Durable medical equipment.

(b) Claims for pharmacy services containing national drug codes are to be included in the pharmacy claims file, but excluded from the medical claims file.

(c) Member Eligibility File Exclusions. Members without medical or pharmacy coverage for the month reported shall be excluded.

(11) File Format. Each file submission shall be an ASCII file, variable field length, and asterisk delimited. When asterisks are used in any

field values, the entire value shall be enclosed in double quotes.

(12) Insured Group or Policy Number Key Look-up Table. Reporters are required to submit a key look-up table when submitting member eligibility files. The key look-up table shall link Insured Group or Policy Number (ME006) to the name of the group associated with each Insured Group or Policy Number, but shall not identify any individual policyholders in connection with non-group policies.

(13) Header and Trailer Records. Each member eligibility file and each medical and pharmacy claims file submission shall contain a header record and a trailer record. The header record is the first record of each separate file submission and the trailer record is the last. The header and trailer record formats shall be as detailed in Appendices B-1 and B-2.

(14) Pharmacy Claims. Claims for pharmacy services shall be included in the following files:

(a) If the pharmacy claims are covered under the medical benefit then the claim shall be included in the medical claims file and not the pharmacy claims file; and

(b) If the claim is covered under the prescription benefit then the claim shall be included in the pharmacy claims file.

(15) Prepaid Amount. Any prepaid amounts are to be reported in a separate field in the medical and pharmacy claims file submissions.

(16) Supplemental Health Insurance. Claims related to supplemental health insurance are to be included if the policies are for health care services entirely excluded by the Medicare, Tricare, or other publicly funded health benefit programs.

B. Detailed File Specifications.

(1) Filled Fields. All required fields shall be filled where applicable. Non-required text, date, and integer fields shall be set to null when unavailable. Non-applicable decimal fields shall be filled with one zero and shall not include decimal points when unavailable.

(2) Position. All text fields are to be left justified. All integer and decimal fields are to be right justified.

(3) Signs. Positive values are assumed and need not be indicated as such. Negative values must be indicated with a minus sign and must appear in the left-most position of all integer and decimal fields. Over-punched signed integers or decimals are not to be utilized.

(4) Individual Elements and Mapping. Individual data elements, data types, field lengths, field description/code assignments, and mapping locators (UB-04, HCFA 1500, ANSI X12N 270/271, 835, 837) for each file shall be as detailed in the following appendices:

(a) (1) Member Eligibility File Specifications – Appendix C-1

(2) Member Eligibility File Mapping to National Standard Formats – Appendix C-2

(b) (1) Medical Claims File Specifications – Appendix D-1

(2) Medical Claims File Mapping to National Standard Formats – Appendix D-2

(c) (1) Pharmacy Claims File Specifications – Appendix E-1

(2) Pharmacy Claims File Mapping to National Standard Formats – Appendix E-2

Section 6: Submission Requirements

Data submission requirements shall be as detailed in the attached appendices.

A. Registration Form. It is the responsibility of each Health Insurer to resubmit or amend the registration form required by Section 4 (A) whenever modifications occur relative to the data files or contact information.

B. File Organization. The member eligibility file, medical claims file and pharmacy claims file shall be submitted to BISHCA or its designee as separate ASCII files. Each record shall terminate with a carriage return (ASCII 13) or a carriage return line feed (ASCII 13, ASCII 10).

C. Filing Media. Files shall be submitted utilizing one of the following media: diskette (1.44 MB),

CD-ROM (650 MB), DVD, secure SSL web upload interface, or electronic transmission through a File Transfer Protocol. E-mail attachments shall not be accepted. Space permitting, multiple data files may be submitted utilizing the same media if the external label identifies the multiple files.

D. Transmittal Sheet. All file submissions on physical media shall be accompanied by a hard copy transmittal sheet containing the following information: identification of the Reporter, file name, type of file, data period(s), date sent, record count(s) for the file(s), and a contact person with telephone number and E-mail address. The information on the transmittal sheet shall match the information on the header and trailer records. See Appendix I.

E. Testing of Files. At least sixty days prior to the initial submission of the files or whenever the data element content of the files as described in Section 5 is subsequently altered, each Reporter shall submit to BISHCA or its designee a data set for comparison to the standards listed in Section 7. The size, based upon a calendar period of one month, quarter, or year, of the data files submitted shall correspond to the filing period established for each Reporter under subsection I of this Section.

F. Rejection of Files. Failure to conform to subsections A, B, or C of this Section shall result in the rejection and return of the applicable data file(s). All rejected and returned files shall be resubmitted in the appropriate, corrected form to BISHCA or its designee within 10 days.

G. Replacement of Data Files. No Reporter may replace a complete data file submission more than one year after the end of the month in which the file was submitted unless it can establish exceptional circumstances for the replacement. Any replacements after this period must be approved by BISHCA. Individual adjustment records may be submitted with any monthly data file submission.

H. Run-Out Period. Reporters shall submit medical and pharmacy claims files for at least a six month period following the termination of coverage date for all members who are Vermont residents or non-residents receiving covered services provided by Vermont health care providers or facilities.

I. Data Submission Schedule. The reporting period for submission of each specified file listed in Section 5 shall be determined on a separate basis for Vermont members and non-resident members by the highest total number of Vermont resident members or non-resident members receiving covered services provided by Vermont providers or facilities for which claims are being paid for any one month of the calendar year. Data files are to be submitted in accordance with the following schedule:

Total # of Members	Reporting Period	Reporting Schedule
≥2,000	Monthly	Prior to the end of the month following the month in which claims were paid
500-1,999	Quarterly	Prior to April 30, July 31, October 31, January 31 for each preceding calendar quarter in which claims were paid
200-499	Annually	Prior to April 30 of the following year for the preceding twelve months in which claims were paid
<200	N/A	

If the data files submitted by an individual Reporter support or are related to the files submitted by another Reporter, BISHCA shall establish a filing period for the parties involved.

Section 7: Compliance with Data Standards

A. Standards. BISHCA or its designee shall evaluate each member eligibility file, medical claims file and pharmacy claims file in accordance with the following standards:

(1) The applicable code for each data element shall be as identified in Appendices C-1, D-1,

and E-1 and shall be included within eligible values for the element;

(2) Coding values indicating "data not available", "data unknown", or the equivalent shall not be used for individual data elements unless specified as an eligible value for the element;

(3) Member sex, diagnosis and procedure codes, and date of birth and all other date fields shall be consistent within an individual record;

(4) Member identifiers shall be consistent across files; and

(5) Files submitted shall not contain direct personal identifiers.

B. Notification. Upon completion of this evaluation, BISHCA or its designee will promptly notify each Reporter whose data submissions do not satisfy the standards for any reporting period. This notification will identify the specific file and the data elements that are determined to be unsatisfactory.

C. Response. Each Reporter notified under subsection 7.B shall resubmit within 60 days of the date of notification with the required changes.

D. Compliance. Failure to file, report, or correct health care claims data sets in accordance with the provisions of this regulation may be considered a violation of 18 V.S.A. § 9410(g).

Section 8: Procedures for the Approval and Release of Claims Data

The requirements, procedures and conditions under which persons other than the Department may have access to health care claims data sets and related information received or generated by the Department or its designee pursuant to this regulation shall depend upon the requestor and the characteristics of the particular information requested, all as set forth below.

A. Classification of Data Elements

(1) Unrestricted Data Elements: Data elements designated in Appendix J as "Unrestricted" shall be available for general use and public release as part of a Public Use File.

(2) Restricted Data Elements: Data elements designated in Appendix J as "Restricted" shall not be available for use and release outside the Department except as part of a Limited Use Research Health Care Claims Data Set approved by the commissioner pursuant to the requirements of this regulation.

(3) Unavailable Data Elements: Data elements which are not designated in Appendix J as either Unrestricted or Restricted, or are designated as "Unavailable", shall not be available for release or use outside the Department in any data set or disclosed in publicly released reports in any circumstance.

B. Public Use Data Sets: Release and Availability

(1) Unrestricted Data Elements collected or generated by the Department or its designee

shall be made available in public use files and provided to any person upon written request, except where otherwise prohibited by law.

(2) The Department shall maintain a public record of all requests for and releases of public use data sets.

C. Limited Use Health Care Claims Research Data Sets – Release and Availability

(1) Limited Use Health Care Claims Research Data Sets shall be those sets which contain restricted data elements, shall not be available to the general public and shall be released to a requestor only for the purpose of research upon a determination by the Commissioner that the following conditions have been met:

(a) Application: Any person requesting access to or use of Limited Use Health Care Claims Research Data Sets shall submit an application, in written and electronic form, to the Commissioner disclosing the information listed below. Studies utilizing data sets for longer than 2 years may be required to reapply.

(1) Identity of principal investigator:

(a) Name, address, and phone number;

(b) Organizational affiliation;

(c) Professional qualification; and

(d) Phone number of principal investigator's contact person, if any.

(2) Identity of person requesting access, including any entities for whom that person is acting in requesting the data.

(a) Name, address, and phone number;

(b) Organizational affiliation;

(c) Professional qualification; and

(d) Name and phone number of contact person.

(3) Identity of and qualifications of any other persons who may have access to the data.

(4) A detailed research protocol, to include:

(a) A summary of background, purposes, and origin of the research;

(b) A statement of the health-related problem or issue to be addressed by the research;

(c) The research design and methodology, including either the topics of exploratory research or the specific research hypotheses to be tested;

(d) The procedures that will be followed to maintain the confidentiality of any data or copies of

records provided to the principal investigator or other persons; and

(e) The intended research completion date;

(5) Particular data set requested, including:

(a) The time period of the data requested;

(b) The specific data elements or fields of information required;

(c) A justification of the need for each restricted element or field, as identified in the data release schedule;

(d) The minimum needed specificity of the requested data elements, including the manner in which the data may be recoded by the department to be less specific;

(e) The selection criteria for the minimum needed data records required; and

(f) Any particular format or layout of data requested by the principal investigator.

(6) Any changes to information submitted as part of an application pursuant to (a)(1)-(4) shall require notice

to the Department by the applicant and shall be subject to the approval of the Commissioner.

(b) The person or entity requesting access and the principal investigator or investigators shall be subject to the following requirements and limitations and shall, in addition, sign and submit a data use agreement acknowledging and accepting these same provisions as a necessary condition to any data access:

(1) Use of data for any purpose other than as specified in the application and approved by the Commissioner shall be prohibited;

(2) Appropriate safeguards to protect the confidentiality of the data and prevent unauthorized use of the data shall be established;

(3) The use or disclosure, sale, or dissemination of the data set or statistical tabulations derived from the data set to any person or organization for any purpose other than as described in the application and as permitted by the data use agreement shall be prohibited without the express written consent of the Commissioner.

(4) The use or disclosure, sale, or dissemination of any information contrary to law shall be prohibited;

(5) No person shall disclose the identity of patients, employer groups or purchaser groups from information contained in the limited use data set;

(6) No person shall disclose any of the information that has been encrypted or removed from the data;

(7) The content of cells that contain counts of persons in statistical tables in which the cell size is more than 0 and less than 5 shall not be disclosed, published or made public in any manner except as "<5";

(8) The publication, dissemination or disclosure of any information that could be used to identify providers of abortion services shall be prohibited;

(9) Any use or disclosure of the information that is contrary to the Data Use Agreement or this Regulation shall be reported to the Department within five (5) days of when the principal investigator becomes aware of such disclosure.

(10) The Department and the "Vermont Healthcare Claims Uniform Reporting and Evaluation System" shall be acknowledged as the source and owner of the data in any and all public reports, publications, or

presentations generated from the data;

(11) Written materials shall prominently state that the analyses, conclusions and recommendations drawn from such data are solely those of the requestor or principal investigator and are not necessarily those of the Department;

(12) The Department shall be provided with a copy of any proposed report or publication containing information derived from the data at least 15 days prior to any publication or release to allow the department to review the proposed report or publication and confirm that the conditions of the agreement have been applied. When multiple reports of a similar nature will be created from the data, the Department may, on request, waive the requirement that any subsequent reports or publications be provided to the Department prior to release by the requesting party

(13) Data elements shall not be retained for any period of time beyond that necessary to fulfill the requirements of the data request.

(14) Within 30 days after the scheduled completion date of the project, the requestor shall delete, destroy or

otherwise render the data unreadable, so certifying by submitting a written notice to the Department or by reapplying for approval if the end date of the project needs to be extended;

(15) Any draft reports or publications supplied to the department shall be considered confidential and exempt from public review under 1 V.S.A. §315 et seq. and shall not be released by the Department; and

(16) Failure to adhere to the data use agreement or the limitations and restrictions detailed above will be cause for immediate recall by the Department of the data, revocation of permission to use the data, and grounds for civil or administrative enforcement action by the Department under applicable Vermont state law.

(c) The Department shall establish a claims data release advisory committee with a chair person and members appointed annually by the Commissioner, to provide non-binding advice and opinion to the Commissioner, as and when requested, on the merits of applications for access to limited use data sets. If the Commissioner has requested a review of the application, the claims data release advisory committee shall provide the

Commissioner with any comment on the merits of the application and the research protocol described therein within thirty (30) days. The committee shall be comprised of seven (7) members and include:

(1) At least one member representing health insurers;

(2) At least one member representing health care facilities;

(3) At least one member representing health care providers;

(4) At least one member representing purchasers of health insurance or health benefits; and

(5) At least one member representing healthcare researchers.

(2) The Commissioner may approve the release of limited use data sets only when the Commissioner is satisfied as to the following:

(a) The application submitted is complete and the requesting individuals or entities and principal investigator have signed a data use agreement as specified;

(b) Procedures to ensure the confidentiality of any patient and any confidential data are documented;

(c) The qualifications of the investigator and research staff, as evidenced by:

(1) Training and previous research, including prior publications; and

(2) An affiliation with a university, private research organization, medical center, state agency, or other qualified institutional entity.

(d) No other state or federal law or regulation prohibits release of the requested information.

(3) If the Commissioner declines to release the requested limited use data sets within 60 days of receipt of a complete application, the Department shall give written notice of the basis for denial of the application and the requestor shall have leave to resubmit or supplement the application to address the Commissioner's concerns. Any adverse decision regarding an application may be appealed within 30 days by filing a request for hearing with the Commissioner pursuant to Department Rule 82-1.

Section 9: Prices for Data Sets, Fees for Programming and Report Generation, Duplication Rates

This Section lists the prices for data sets from the Vermont Healthcare Claims Uniform Reporting and Evaluation System, including the fees for programming and report generation, duplicating charges and other costs associated with the production and transmission of data sets approved for release by the Department.

A. An annual public use file consisting of unrestricted fields and data elements shall be made available to any person upon request at the cost required for the Department to process, package and ship the data set, including any electronic medium used to store the data.

B. Limited Use Research Health Care Claims Data Sets approved by the Department shall be made available to the requesting party at the cost charged by the Department's designated vendor to program and process the requested data extract, including any consulting services and costs to package and ship the data set on particular electronic medium.

C. Payments are due in full from the requesting party within thirty days of receipt of BISHCA data sets, files, reports, or other released material.

Section 10: Enforcement

Violations of data submission requirements, confidentiality requirements, data use limitations or any other provisions of this rule shall be subject to sanction by the Commissioner as set out in 18 V.S.A. §9410 in addition to any other powers granted to the Commissioner to investigate, subpoena, fine or seek other legal or equitable remedies.

Section 11: Severability

If any provision of this regulation or the application thereof to any person or circumstance is for any

reason held to be invalid, the remainder of the regulation and the application of such provisions to other persons or circumstances shall be not affected thereby.

OPPOSITION BRIEF

No. 14-181

IN THE

Supreme Court of the United States

ALFRED GOBEILLE, in his official capacity as chair of the Vermont Green Mountain Care Board,
Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,
Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF IN OPPOSITION

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QUESTION PRESENTED

Vermont has enacted legislation and implementing regulations that require "health insurers" to regularly submit to the State "medical claims data, pharmacy claims data, member eligibility data, provider data, and other information relating to health care" for use in Vermont's unified health care database. Health insurers—which Vermont defines as including, "to the extent permitted under federal law," the administrators of self-insured health care benefit plans—must submit annual registration forms and report claims data at specified intervals (monthly for some insurers) in a format prescribed by the State.

The question presented is:

Whether the Employee Retirement Income Security Act of 1974 preempts Vermont's reporting mandates insofar as they require self-insured plans governed by ERISA to submit data about claims paid under the terms of the plan.

PARTIES TO THE PROCEEDING

The petition in this matter has been filed by Alfred J. Gobeille, in his official capacity as Chair of the Green Mountain Care Board. Chair Gobeille was not a party to the proceedings below, however. The defendant in the district court and the original appellee was Commissioner Stephen W. Kimbell, in his official capacity as the Vermont Commissioner of Banking, Insurance, Securities, and Health Care Administration. Commissioner Susan L. Donegan was substituted for Commissioner Kimbell when she replaced him in office.

Chair Gobeille now claims that he has been substituted for Commissioner Donegan under Supreme Court R. 35.3 "because the Vermont Legislature shifted responsibility for the unified health care database to the Green Mountain Care Board, effective June 7, 2013" (Pet. ii). As discussed below (at 10-13), Chair Gobeille has not been properly substituted for Commissioner Donegan because the relevant enforcement functions of her office—the issuance and enforcement of the subpoena giving rise to this litigation—have not been transferred to the Green Mountain Care Board. Accordingly, Chair Gobeille is not a party to this action entitled to petition for certiorari under 28 U.S.C. § 1254(1).

Respondent Liberty Mutual Insurance Company was the plaintiff in the district court and the appellant in the court of appeals.

CORPORATE DISCLOSURE STATEMENT

Pursuant to Supreme Court Rule 29.6, respondent Liberty Mutual Insurance Company ("Liberty Mutual") states that it is a wholly owned subsidiary of Liberty Mutual Group Inc. No publicly held company owns 10% or more of the stock of Liberty Mutual Group.

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IN THE

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No. 14-181

ALFRED GOBEILLE, in his official capacity as chair of the Vermont Green Mountain Care Board,
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Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1-47) is reported at 746 F.3d at 497. The opinion of the district court (Pet. App. 48-80) is not reported but is available at 2012 WL 5471225.

JURISDICTION

The judgment of the court of appeals was entered on February 4, 2014. A petition for rehearing was denied on May 16, 2014. The petition for a writ of certiorari was filed on August 13, 2014. Although this Court's jurisdiction is invoked under 28 U.S.C. § 1254(1), as explained below (at 10-13), this Court lacks jurisdiction because no proper petitioner is before the Court.

STATUTES INVOLVED

In addition to the statutes and regulations reprinted in the appendix to the petition, this case involves 8 V.S.A. § 13, which is reprinted in an appendix to this brief. App. 1a.

STATEMENT

A. Vermont's Reporting Requirements

In 2008, the Vermont Department of Financial Regulation (the Department)[1] promulgated Regulation H-2008-01, which created the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES). Pet. App. 5. The Department promulgated Regulation H-2008-01 pursuant to a Vermont statute, 18 V.S.A. § 9410 (the Database Statute), that directed the Commissioner of the Department to "establish[] and maintain[] a unified health care database" (Pet. App. 99), as well as pursuant to its authority under 8 V.S.A. § 15(a) to "adopt rules and issue orders as shall be authorized by or necessary to the administration ... of 18 V.S.A. chapter 221." Pet. App. 107 (Regulation H-2008-01 §2).

The Database Statute required "[h]ealth insurers, health care providers, health care facilities, and governmental agencies" to file those "reports, data, schedules, statistics, or other information" determined by the Commissioner of the Department to be necessary. Pet. App. 99, 101 (18 V.S.A. §§ 9410(a)(1), 9410(c) (pre-2013

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[1] At that time, the Vermont Department of Financial Regulation was known as the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA). For simplicity, this brief will refer to both BISHCA and the current Department of Financial Regulation as "the Department."

version)). The Database Statute also granted the Commissioner the power to "establish the types of information to be filed ... and the time and place and the manner in which such information shall be filed." Pet. App. 102 (18 V.S.A. § 9410(d) (pre-2013 version)). Regulation-H-2008-01, which is still in force as a Department regulation, sets forth those reporting requirements. Pet. App. 107 (Regulation H-2008-01, § 1).

Under Regulation H-2008-01, "health insurers"—which the regulation defines to include, "to the extent permitted under federal law," the administrators of self-insured health care benefit plans (Pet. App. 112-113 (§ 3(X)))—must register annually with the Department and must "identify whether health care claims are being paid for members who are Vermont residents and whether health care claims are being paid for non-residents receiving covered services from Vermont health care providers." Pet. App. 116 (§ 4(A)). The regulation further provides that "[h]ealth insurers shall regularly submit medical claims data, pharmacy claims data, member eligibility data, provider data, and other information" in accordance with the regulation's data submission requirements. Pet. App. 117-118 (§ 4(D)).

The data submission requirements regulate, among other things, the content, coding, encryption, and file format of the data. Pet. App. 119-124 (§ 5(A)). The regulation also includes detailed file specifications that dictate such minutiae as the placement of decimal points and the justification of text fields. Pet. App. 124 (§ 5(B)). Data must be submitted on a prescribed schedule, which varies from monthly to quarterly to annually, depending on the number of members living or receiving services in Vermont. Pet. App. 127-128 (§ 6(I)). Insurers with fewer than 200 enrolled or covered members living or receiving services in Vermont

are considered voluntary reporters and may, but are not required to, submit data for use in the database. Pet. App. 113, 116, 118, 128 (§§ 3(Ab), 3(As), 4(E), 6(I)).

The Database Statute required the Commissioner to "adopt a confidentiality code to ensure" that the collected information "is handled in an ethical matter." Pet. App. 102 (18 V.S.A. § 9410(f) (pre-2013 version)). The statute also provided, however, that, "[t]o the extent allowed by" the federal Health Insurance Portability and Accountability Act (HIPAA) and without publicly disclosing data with direct personal identifiers, "the data shall be available as a resource for insurers, employers, providers, purchasers of health care, and state agencies." Pet. App. 104 (18 V.S.A. § 9410(h)(3)(B), (D) (pre-2013 version)). Regulation H-2008-01 contains procedures for releasing claims data to the public and creates three categories—"unrestricted," "restricted," and "unavailable"—that determine the data's availability to the public. Pet. App. 130.

Vermont law empowers the Commissioner to "issue subpoenas, examine persons, administer oaths and require production of papers and records" to enforce 18 V.S.A. chapter 221, which includes the Database Statute. App. 1a (8 V.S.A. § 13(a)). The Commissioner may also impose financial penalties on, and suspend the authority to do business of, any person who fails to comply with a subpoena. App. 1a-2a (§ 13(b)). Regulation H-2008-01, § 10 authorizes the Commissioner to seek administrative penalties for violations of its provisions "in addition to any other powers granted to the Commissioner to investigate, subpoena, fine or seek other legal or equitable remedies." Pet. App. 140.

B. Prior Proceedings

1. Liberty Mutual Insurance Company is the administrator and named fiduciary of a self-insured employee health plan that provides benefits to more than 80,000 individuals nationwide (the Plan). Pet. App. 7. The documents that govern the Plan recite that the "Plan has been established for the exclusive benefit of Participants" and that "all contributions under the Plan may be used only for such purpose." Pet. App. 8. The Plan also represents that participants' medical records are kept "strictly confidential." *Id.*

Liberty Mutual uses a third-party administrator, Blue Cross Blue Shield of Massachusetts, Inc. ("Blue Cross") to handle processing, reviewing, and paying claims for Vermont participants in the Plan. Pet. App. 8. Liberty Mutual has a contract with Blue Cross that requires Blue Cross to use information it receives from Liberty Mutual solely for purposes of administering the Plan and to guard against unauthorized disclosure of the information. Pet. App. 51.

Both Liberty Mutual and Blue Cross are considered "health insurers" and are subject to Vermont's reporting requirements. Pet. App. 54. Although Liberty Mutual has fewer than 200 participants or beneficiaries in Vermont and is thus a voluntary reporter, Blue Cross is a mandatory reporter and must therefore report, for participants in the Plan, the claims data that are in its possession. Pet. App. 8.

2. In 2011, the Commissioner, exercising his authority under 8 V.S.A. § 13(a), issued a subpoena to Blue Cross seeking medical and pharmacy claims files, as well as other information, for use in Vermont's health care database. App. 3a. Liberty Mutual directed Blue Cross not to comply with the subpoena and

filed a complaint against the Commissioner, seeking a declaration that Vermont's reporting regime is preempted by ERISA to the extent it requires the reporting of data relating to plan participants and an injunction against enforcement of the subpoena. Pet. App. 9. The district court granted summary judgment for the Commissioner, concluding that Vermont's law and regulations are not preempted by ERISA. Pet. App. 61-79.[2]

3. Liberty Mutual appealed to the Second Circuit. While the case was pending on appeal, the Vermont Legislature transferred some of the Commissioner's responsibilities under the Database Statute to the Chair of the Vermont Green Mountain Care Board. 18 V.S.A. § 9410 (2013 version). The Commissioner retained the authority to enforce the subpoena at issue in this case, however, and no attempt was made to substitute the Chair of the Vermont Green Mountain Care Board for the Commissioner as the proper party to this case. Nor did the Chair of the Board move to intervene.

The court of appeals reversed and remanded the case with instructions to enter judgment for Liberty Mutual. Pet. App. 1-47. The court held that ERISA preempts Vermont's reporting requirements as applied to compel the reporting of Liberty Mutual's plan data. Pet. App. 4, 9-10.

For guidance, the court looked to the "modern ERISA preemption test" set forth in *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983): "[A]state law is

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[2] The district court also ruled that Liberty Mutual had Article III standing to bring suit. Pet. App. 56-61. The court of appeals affirmed that ruling. Pet. App. 9-10.

preempted if 'it [1] has a connection with or [2] reference to [an ERISA] plan.'" Pet. App. 14 (emphasis omitted). The court then observed that, in *Shaw*, this Court had "treated as obvious that ERISA preempted 'state laws dealing with the subject matters covered by ERISA—*reporting, disclosure*, fiduciary responsibility, and the like.'" *Id.* (quoting *Shaw*, 463 U.S. at 98).

The court of appeals did take note of this Court's "caution" in *Shaw* that "[s]ome state actions may affect employee benefits plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." Pet. App. 14 (quoting *Shaw*, 463 U.S. at 100 n.21). And it observed that decisions subsequent to *Shaw*, including *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, 514 U.S. 645 (1995), "marked something of a pivot in ERISA preemption." Pet. App. 18. *Travelers*, the court explained, stated a "'starting presumption that Congress does not intend to supplant state law.'" *Id.* (quoting *Travelers*, 514 U.S. at 655). Nonetheless, the court observed that *Travelers* itself reaffirmed that ERISA alone "'controls the administration of benefit plans, as by imposing *reporting and disclosure mandates*.'" Pet. App. 19-20 (quoting *Travelers*, 554 U.S. at 651). Thus, the court explained, recent precedents have not changed two constants: "(1) recognition that ERISA's preemption clause is intended to avoid a multiplicity of burdensome state requirements for ERISA plan administration; and (2) acknowledgement that 'reporting' is a core ERISA administrative function." Pet. App. 3-4.

Applying those principles, the court concluded that Vermont's reporting requirements are preempted as applied to ERISA plans because those requirements have a "'connection with' ERISA plans." Pet. App. 23.

The court relied on "the principle (undisturbed in *Travelers*) that 'reporting' is a core ERISA function shielded from potentially inconsistent and burdensome state regulation." *Id.* The court acknowledged that "[n]ot every state law imposing a reporting requirement is preempted" and that ERISA tolerates "laws that create no impediment to an employer's adoption of a uniform benefit administration scheme and with too tenuous, remote, or peripheral an effect on employee benefit plans." Pet. App. 24 (internal quotation marks, citations, and brackets omitted). But, the court stressed, Vermont has required the reporting of "information about the essential functioning of employee health plans." Pet. App. 29 n.13.

The court also found preemption to be supported here by the need "to avoid proliferation of state administrative regimes" that would subject Liberty Mutual to overlapping and potentially conflicting requirements. Pet. App. 21. In response to the argument that preemption should not apply to Vermont's reporting requirements because they differ from the reporting requirements in ERISA, the court observed that "[a] hodge-podge of state reporting laws, each *more* onerous than ERISA's uniform federal reporting regime, and seeking different and additional data, is exactly the threat that motivates ERISA preemption." Pet. App. 24 n.11. The court concluded that the burden of Vermont's reporting requirements, when "considered as one of several or a score of uncoordinated state reporting regimes," was "obviously intolerable." Pet. App. 25.

In sum, the court concluded that ERISA "does not allow one of ERISA's core functions—reporting—to be laden with burdens, subjected to incompatible, multiple and variable demands, and freighted with risk of fines, breach of duty, and legal expense." Pet. App. 29. The

court accordingly reversed the district court's judgment and remanded with instructions to enter judgment for Liberty Mutual. Pet. App. 30.[3]

ARGUMENT

The court of appeals correctly ruled that ERISA preempts a state law that requires ERISA plans to report to the state data about claims paid under the terms of the plan. That decision faithfully applies this Court's precedents on ERISA preemption and was informed by the same factors that this Court has invoked when it has held state laws preempted by ERISA. That decision also does not conflict with the decision of any other court of appeals. Petitioner's dire warnings about the potential implications of the court of appeals' decision are overstated and were largely anticipated and rebutted by the court of appeals. This Court's intervention is therefore not necessary.

Review should also be denied because this Court lacks jurisdiction over the petition. The petition was filed by the Chair of the Green Mountain Care Board, but that officer was not a party to the proceedings in the court of appeals. Petitioner claims to have been automatically substituted for the defendant below, the Commissioner of the Department of Financial Regulation, but the Commissioner retains the sole authority to enforce the subpoena at issue, and the Commissioner has not petitioned for review in this Court. No proper petitioner is therefore before this Court. Should the issues raised by the petition prove to have long-lasting

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[3] Judge Straub dissented in part. He would have concluded that the Vermont reporting requirements are not preempted by ERISA. Pet. App. 30-47.

significance, this Court can consider them in a case not presenting these serious jurisdictional difficulties.

I. THIS CASE IS A POOR VEHICLE FOR REVIEW BECAUSE NO PROPER PETITIONER IS BEFORE THE COURT

This Court has jurisdiction to review cases in the court of appeals "[b]y writ of certiorari granted upon the petition of *any party* to any civil or criminal case." 28 U.S.C. § 1254(1) (emphasis added). The petitioner here, the Chair of the Vermont Green Mountain Care Board, was not a "party" to this case when it was in the court of appeals and did not move to intervene in the case. The defendant-appellee in the court of appeals was the Commissioner of the Vermont Department of Financial Regulation. The Commissioner has not joined the petition. Moreover, any attempt by the Commissioner to petition for certiorari at this stage would be untimely. S. Ct. R. 13. Accordingly, this Court lacks jurisdiction over the petition unless the petitioner is properly substituted for the Commissioner. But substitution is not proper, because the Commissioner of the Department of Financial Regulation, not the Chair of the Vermont Green Mountain Care Board, retains the authority to take the action that is at the core of this dispute—to enforce the subpoena that the Commissioner issued to Blue Cross.

Petitioner claims to have been substituted for the Commissioner under this Court's Rule 35.3 "because the Vermont Legislature shifted responsibility for the unified health care database to the Green Mountain Care Board, effective June 7, 2013." Pet. ii; *see* Pet. 5 n.1. In fact, the Chair of the Green Mountain Care Board has not succeeded to the Commissioner's en-

forcement function at issue in this case: the Commissioner's issuance of a subpoena to Liberty Mutual.[4] At the very least, there are serious questions surrounding the Chair's party status, and thus this Court's jurisdiction under § 1254(1), that counsel against granting certiorari in this case. Should the decision below have the serious ramifications that petitioner ascribes to it—which is not the case in any event (*see infra* pp. 29-32)—there will doubtless be later cases, not presenting these jurisdictional difficulties, in which this Court can examine the application of ERISA preemption principles in this context.

Vermont has shifted authority for maintaining Vermont's health care database to the Green Mountain Care Board. The Board has authority under Title 18 of the Vermont Statutes to enforce compliance with the Database Statute. *See* 18 V.S.A. § 9410(g). But the subpoena that Liberty Mutual has sought to enjoin in this case was issued by the Commissioner pursuant to a different provision. The subpoena was issued by the Commissioner under 8 V.S.A. § 13(a), a part of the title

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[4] Both Fed. R. App. P. 43(c) and S. Ct. R. 35.3 provide that "[w]hen a public officer who is a party ... in an official capacity dies, resigns, or otherwise ceases to hold office, the action does not abate" and that the public officer's successor "is automatically substituted as a party." Neither rule specifically addresses substitution in situations where the relevant enforcement responsibilities are transferred between two different offices, but it has been suggested that such a transfer renders the transferee officer the "successor" for purposes of both rules. Wright et al., *Federal Practice and Procedure* § 1960, at 715 & n.6 (3d ed. 1997). As discussed above, the relevant enforcement responsibilities at issue here have not been transferred from the Commissioner of the Department to the Green Mountain Care Board and thus no transfer that might implicate the rules governing substitution has occurred.

of the Vermont statutes covering regulation of insurance. App. 3a. That provision, which remains in place, authorizes the Commissioner "to issue subpoenas, examine persons, administer oaths and require production of papers and records" to enforce various statutory provisions, including "18 V.S.A. chapter 221," which includes the Database Statute. App. 1a. The authority to issue and enforce subpoenas under Title 8, including the subpoena in this case, remains with the Commissioner of the Department and was never transferred to the Green Mountain Care Board.[5]

The Chair of the Green Mountain Care Board does have a separate subpoena power, under Title 18 of the Vermont Code (18 V.S.A. § 9374(i)), but the subpoena involved in this case was not issued under that statute. Moreover, the Chair does not have the same power to punish noncompliance with a subpoena as does the Commissioner. Whereas the Commissioner can suspend the authority to do business of any person who fails to comply with a subpoena under Title 8, the Chair may only "recommend to the appropriate licensing entity that the person's authority to do business be suspended for up to six months." *Id.* § 9374(j).

Under these circumstances, the Commissioner's relevant enforcement function has not been transferred to the Chair of the Green Mountain Care Board. The

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[5] The Commissioner also retains separate authority, under Chapter 221 of Vermont Code Title 18, "in the case of health insurers, [to] enforce a violation of a provision of this subchapter [which includes the Database Statute], or a rule adopted pursuant to a provision of this subchapter, as a violation of a requirement of Title 8 relating to health insurers." 18 V.S.A. § 9412(b). Thus, not all of the Commissioner's responsibilities under the Database Statute were transferred to the Board.

Chair therefore cannot be substituted for the Commissioner as a party to this case. And as the Chair of the Board has not been substituted for the Commissioner, he is not a "party" entitled to petition for certiorari under 28 U.S.C. § 1254(1). "A 'party' to litigation is one by or against whom a lawsuit is brought." *United States ex rel. Eisenstein* v. *City of New York*, 556 U.S. 928, 933 (2009). The Chair was not named as a defendant to the complaint, nor did he participate in the appeal before the Second Circuit, even after the Green Mountain Care Board assumed responsibility for Vermont's health care database.[6] The Chair also did not seek leave to intervene in the court of appeals on the ground that the Board's functions might be affected by the decision. This Court therefore lacks jurisdiction over the petition for certiorari.[7]

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[6] The petition for rehearing in the court of appeals was filed on February 18, 2014, well after Vermont shifted responsibility to the Green Mountain Care Board, yet the petition was still filed by the Commissioner of the Department of Financial Regulation, not the Chair.

[7] This conclusion that the Chair of the Board is not a "party" to this case is not altered by the fact that Liberty Mutual sought declaratory relief in its complaint as well as an injunction against the Commissioner from seeking to enforce the subpoena. Had the Chair thought that declaratory relief implicated the Board's interests beyond the subpoena at issue in this case, he was free to move to intervene in the court of appeals. *See Goodman* v. *Heublein, Inc.*, 682 F.2d 44, 47 (2d Cir. 1982); *ABB Industrial Sys., Inc.* v. *Prime Tech., Inc.*, 120 F.3d 351 (2d Cir. 1997). Having failed to do so, the Chair cannot now assert that he is a party to this case. *See Eisenstein*, 556 U.S. at 936 ("The fact that the Government is bound by the judgment is not a legitimate basis for disregarding this statutory scheme [requiring the government to intervene to become a party].").

II. THE COURT OF APPEALS' DECISION IS CORRECT

ERISA provides that it "'shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan' covered by ERISA." *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 146 (2001) (quoting 29 U.S.C. § 1144(a)). Under this Court's precedents, "a state law relates to an ERISA plan 'if it has a connection with or reference to such a plan.'" *Id.* at 147 (quoting *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)).

Petitioner does not and cannot claim that the Second Circuit failed to apply *Shaw*'s two-part test when it held that Vermont's reporting requirements "have a 'connection with' ERISA plans." Pet. App. 23. Rather, petitioner claims that the court adopted an "expansive and literal" approach inconsistent with this Court's application of the "connection with" test for ERISA preemption. Pet. 16. In fact, the Second Circuit faithfully applied this Court's ERISA decisions and reached a conclusion that reflects the proper scope of ERISA's preemption provision.

A. The Decision Below Reflects A Proper Application Of ERISA Preemption Principles Under This Court's Precedents

The court of appeals ruled in this case that a state law that requires an ERISA plan to report to the state data about claims paid under the terms of a plan is preempted by ERISA. That decision is consistent with this Court's precedents stating that ERISA, at a minimum, preempts "state laws dealing with the subject matters covered by ERISA." *Shaw*, 463 U.S. at 98. Vermont's requirements fall squarely within the realm that Congress reserved exclusively to the federal regime governing ERISA plans, for they require ERISA

plans to account and report to the state what the plan has paid out to whom as part of the plan's operations.

1. This Court has repeatedly stated that record-keeping and reporting by employee benefit plans are core matters covered by ERISA. *See California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A.*, 519 U.S. 316, 330 (1997) (listing "reporting" as an area with which ERISA is centrally concerned); *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, 514 U.S. 645, 661 (1995) ("reporting" is a subject matter covered by ERISA); *FMC Corp.* v. *Holliday*, 498 U.S. 52, 58 (1990) (same); *Shaw*, 463 U.S. at 98 (same); *see also Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 9 (1987) (identifying "keeping appropriate records in order to comply with applicable reporting requirements" as an obligation of employee benefit plans). Relying on those well-established principles, the Second Circuit correctly concluded that Vermont's reporting requirements—which mandate the "reporting of health claims, pharmacy claims, etc., information about the essential functioning of employee health plans" (Pet. App. 29)—implicate "a core ERISA function shielded from potentially inconsistent and burdensome state regulation" (Pet. App. 23).[8]

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[8] The Second Circuit's decision is also consistent with this Court's summary affirmance of the Ninth Circuit's decision in *Standard Oil Co. of California* v. *Agsalud*, 633 F.2d 760 (1980), and this Court's later statements about that case in *Fort Halifax*. In *Agsalud*, the Ninth Circuit affirmed a district court decision which held that ERISA preempted a Hawaii statute that "required workers in the State to be covered by a comprehensive prepaid health care plan" and imposed "certain reporting requirements which differ[ed] from those of ERISA." 442 F. Supp. 695,

Although petitioner argues that the court of appeals held that "any type of state reporting requirement must intrude on a core ERISA concern" and thus face preemption (Pet. 19), the Second Circuit made no such ruling. To the contrary, the court of appeals expressly recognized that "[n]ot every state law imposing a reporting requirement is preempted" and noted that ERISA's preemption provision allows for laws that "create no impediment to an employer's adoption of a uniform benefit administration scheme" and have "too tenuous, remote or peripheral an effect on employee benefit plans." Pet. App. 24. As the court made clear, however, Vermont's reporting requirements are different from such laws because they "implicate an ERISA core administrative concern" by requiring ERISA plans to report "information about the essential functioning of employee health plans." Pet. App. 29 n.13.

Taking issue with the court of appeals' conclusion that recordkeeping and reporting about claims payments are core ERISA matters, petitioner argues that Congress's primary concern when it enacted ERISA "was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds" (Pet. 19 (quoting *Dillingham*, 519 U.S. at 326-227)), whereas "Vermont seeks claims data to improve health care

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696 (N.D. Cal. 1977), *aff'd*, 633 F.2d 760 (9th Cir. 1980). After this Court summarily affirmed the Ninth Circuit's decision, *Agsalud* v. *Standard Oil Co. of California*, 454 U.S. 801 (1981), Congress amended ERISA to exempt portions of the Hawaii statute from preemption. But, as this Court observed in *Fort Halifax*, "[t]he amendment did not exempt from pre-emption those portions of the law dealing with reporting, disclosure, and fiduciary requirements." 482 U.S. at 13 n.7.

quality, affordability, and effectiveness" (Pet. 20). According to petitioner, the Vermont reporting requirements do not intrude on an area of core ERISA concern because "Vermont's health care database ... is unrelated to ERISA's core concern with plan administrators' fiduciary responsibilities to beneficiaries." *Id.*

That is an improperly cramped view of both the purpose of ERISA in general and ERISA preemption principles more specifically. When Congress enacted ERISA, it was not just concerned with plan administrators' fiduciary responsibilities. In addition to protecting the interests of beneficiaries, Congress intended to protect plans and employers with self-funded plans (and, ultimately, employees and beneficiaries as well) from the burdens of complying with conflicting state laws by reserving the field of employee benefit plans for federal regulation. *See Aetna Health Inc.* v. *Davila*, 542 U.S. 200, 208 (2004) (purpose of ERISA was to "provide a uniform regulatory regime over employee benefit plans"); *Fort Halifax*, 482 U.S. at 10 (ERISA preemption was intended to minimize interference with the administration of ERISA plans by conflicting state law requirements "so that employers would not have to 'administer their plans differently in each State in which they have employees.'" (quoting *Shaw*, 463 U.S. at 105)). The Vermont reporting requirements operate within that field by requiring the reporting of information "about the essential functioning of employee health plans" (Pet. App. 29 n.13), including the medical claims data and member eligibility data for plan participants (Pet. App. 117-118 (Regulation H-2008-01 §§ 4(D), 5)).

Nor is it relevant, for preemption purposes, that Vermont may have enacted its requirements in order to improve the quality of the State's information about

the availability and cost of health care rather than with the specific purpose of regulating employee benefit plans. Preemption analysis is not restricted to determining whether ERISA and the state law have the same purpose; it also examines the state law's effects on ERISA plans. *See Egelhoff*, 532 U.S. at 147 ("[T]o determine whether a state law has the forbidden connection, we look both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans." (internal quotation marks and citations omitted)).

A state law with a purpose quite different from the purpose that animated Congress can still be preempted if it operates in the same area as a federal law. *Cf. Gade* v. *National Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 107 (1992) ("Whatever the purpose or purposes of the state law, pre-emption analysis cannot ignore the effect of the challenged state action on the pre-empted field."). And even if there is no direct conflict between Vermont's reporting requirements and the reporting requirements in ERISA, that does not mean that there is no preemption. ERISA's preemption provision "was intended to displace all state laws that fall within its sphere, even including state laws that are consistent with ERISA's substantive requirements." *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 739 (1985), *overruled in part on other grounds by Kentucky Ass'n of Health Plans, Inc.* v. *Miller*, 538 U.S. 329 (2003); *see also District of Columbia* v. *Greater Washington Bd. of Trade*, 506 U.S. 125, 129-130 (1992).

2. This Court has also emphasized that ERISA preempts state laws that "interfere[] with nationally uniform plan administration." *Egelhoff*, 532 U.S. at 147. Following that precedent, the court of appeals rightly

concluded that Vermont's reporting scheme imposes "myriad requirements" on ERISA plans. Pet. App. 21, 27. The court recited the litany of requirements that a plan must meet when it reports claims information to Vermont—including requirements governing the content, timing, coding, and encryption of the reports—and properly recognized that those requirements were "burdensome, time-consuming, and risky." Pet. App. 25-27. Thus, the court concluded that, although "[e]ven considered alone, the Vermont scheme triggers preemption," when "considered as one of several or a score of uncoordinated state reporting regimes" Vermont's reporting requirement is "obviously intolerable." Pet. App. 25.

Petitioner claims that the court's focus on the administrative burdens created by the Vermont law was "mistaken[]" (Pet. 21), but the Second Circuit's consideration of those burdens—and the potential that those burdens would be multiplied by the existence of uncoordinated state reporting regimes in different states—is fully consistent with this Court's approach to ERISA preemption.[9] As this Court has recognized, "[o]ne of

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[9] Petitioner also claims that the burdens created by Vermont's reporting requirements do not meet what petitioner considers to be the threshold for preemption under ERISA. Petitioner quotes from this Court's decision in *De Buono* v. *NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806 (1997), to contend that administrative burdens are only relevant if they are "so acute 'as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers.'" Pet. 21. That argument does not reflect a fair reading of the Court's decision in *De Buono*. The quoted language from *De Buono* was a discussion of the circumstances under which preemption might occur as a result of the *economic effects* of a law that addressed a subject area outside of an ERISA plan's core functions. The Court

the principal goals of ERISA is to enable employers 'to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits.'" *Egelhoff*, 532 U.S. at 148 (quoting *Fort Halifax*, 482 U.S. at 9). Accordingly, "differing state regulations affecting an ERISA plan's 'system for processing claims and paying benefits' impose 'precisely the burden that ERISA preemption was intended to avoid.'" *Id.* at 150 (quoting *Fort Halifax*, 482 U.S. at 10).

Petitioner also contends that the court of appeals' description of the burdens imposed by Vermont's reporting requirements was "factually unsupported and wrong." Pet. 22. To the contrary, the court's recognition of the burdens created by Vermont's reporting requirements reflects a common sense assessment of the administrative realities of ERISA plans. ERISA plans "are faced with the task of coordinating complex administrative activities," including "making disbursements" and "keeping appropriate records in order to comply with applicable reporting requirements." *Fort Halifax*, 482 U.S. at 9, 11. Reporting requirements like Vermont's, which require ERISA plans to provide states with specific information in a prescribed format and at prescribed intervals on every claim processed by the plans, directly affect those activities. The burdens that ERISA plans will face from such laws, which differ from state to state and will require ERISA plans to familiarize themselves with the reporting obligations in

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was not addressing the standard for preemption when a state law, such as the Vermont reporting requirements at issue here, imposes direct administrative burdens on the essential functions of an ERISA plan.

each state, should be obvious.[10] *See Egelhoff*, 532 U.S. at 149-150 ("Requiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of 'minimizing the administrative and financial burdens' on plan administrators—burdens ultimately borne by beneficiaries." (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990))); *Fort Halifax*, 482 U.S. at 11 ("A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them."). Indeed, comparing Vermont's reporting requirements to those of other states reveals differences in who is required to report,[11] as well as the timing[12] and content[13] of the required reports.

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[10] Pet. App. 7 ("Data submission requirements vary."); C.A. App. A376 ("[C]urrently each state is collecting different data by different methods and with different definitions").

[11] *Compare* Pet. App. 113 (insurers with 200 or more enrolled or covered members living or receiving services in Vermont are mandatory reporters) *with* Md. Code Regs. tit. 10, § 25.06.03 (reporting entities include payors whose total lives covered exceeds 1,000).

[12] *Compare* Pet. App. 127-128 (§ 6(I)) (varying from monthly to quarterly to annually) *with* Md. Code Regs. tit. 10, § 25.06.05 (quarterly) *and* Utah Admin. Code r. 428-15-3 (monthly).

[13] For example, some states require the reporting of dental claims, while Vermont does not. *Compare, e.g.*, 90-590-243 Me. Code R. § 2 *with* Pet. App. 117; *see also* All-Payer Claims Database Council data for Vermont, http://apcdcouncil.org/state/vermont (last visited Nov. 6, 2014) (types of data collected do not include dental).

3. The Second Circuit's decision is also consistent with this Court's recognition that ERISA preempts state laws that conflict with ERISA's requirement that "the fiduciary 'shall' administer the plan 'in accordance with the documents and instruments governing the plan.'" *Egelhoff*, 532 U.S. at 151 n.4. The court of appeals recognized that Vermont's reporting requirements affect the documents governing Liberty Mutual's ERISA plan by "impair[ing] or (at least) reassign[ing] the obligation in the Plan documents to keep medical records strictly confidential, as well as the undertaking by Blue Cross as [third-party administrator] to use information solely for Plan administration purposes and to prevent unauthorized disclosure." Pet. App. 27. Under the Vermont reporting regime, Vermont makes the data it collects from ERISA plans "available as a resource for insurers, employers, providers, purchasers of health care, and state agencies" and itself decides how much disclosure is appropriate under HIPAA and maintains the "confidentiality code" applicable to the collected information.

Vermont's reporting requirements have an even greater impact on ERISA plans than the law at issue in *Egelhoff*. In *Egelhoff*, the Court held preempted a state statute that allowed employers to opt out of the law by including specific language in the plan documents, because such a statute still "dictate[d] the choices facing ERISA plans with respect to matters of plan administration" as plan administrators had to either follow the beneficiary designation scheme set out in the statute "or alter the terms of their plan so as to indicate that they will not follow it." 532 U.S. at 150. The Court concluded that the statute at issue conflicted with ERISA's command that the plan should be administered in accordance with the plan documents because,

under the state law, the only way the fiduciary could administer the plan according to its terms was to "change the very terms he is supposed to follow." *Id.* at 150-151 n.4. Whereas the law in *Egelhoff* gave ERISA plans a choice between complying with its requirements *or* opting out of the law by including specific language in plan documents, here plan administrators must comply with the reporting obligations imposed by Vermont *and* accept what amounts to an effective amendment of the terms of their plans.

4. Finally, petitioner makes much of a footnote to the Second Circuit's decision in which the court, in a discussion of the presumption against preemption, observed that "state health data collection laws do not regulate the safe and effective provision of health care services" and that "collecting data can hardly be deemed 'historic'" because "most such laws were enacted only within the last ten years." Pet. App. 18-19 n.8. Petitioner claims that, by making those observations, the Second Circuit did not adhere to the presumption against preemption when evaluating Vermont's reporting requirements and thus departed from this Court's precedents.

Those arguments are misguided and in any event identify nothing worthy of this Court's review, for they relate to an issue that ultimately had no impact on the court of appeals' decision. Although the court of appeals remarked that state health data collection laws do not fall within states' historic police powers, it did not hold that such laws are not entitled to the presumption against preemption. Pet. App. 18 n.8. Indeed, at the beginning of its opinion, the court made clear that this Court's precedents had set "a rebuttable presumption against preemption of state health care regulations" but that its conclusion was based on considerations that

remained notwithstanding that presumption. Pet. App. 3-4. Moreover, the court went on to explain that, "[i]n any event, the Supreme Court has repeatedly found the presumption overcome if the state laws upset the deliberate balance central to ERISA, even if those laws implement policies and values lying within the traditional domain of the States." Pet. App. 19 n.8.

Those statements, read in context, make clear that the court concluded that ERISA preempts Vermont's reporting regime even if the Vermont law is entitled to a presumption against preemption. The Second Circuit's comments on the issue of the presumption against preemption are therefore dicta and do not merit review. *See Black* v. *Cutter Labs.*, 351 U.S. 292, 297 (1956) ("This Court reviews judgments, not statements in opinions."); *Halbert* v. *Michigan*, 545 U.S. 605, 632 (2005) (Thomas, J., dissenting) ("[T]his Court would be unlikely to grant certiorari in a case to announce a rule that could not alter the case's disposition, or to correct an error that had not affected the proceedings below.").

B. The Decision Below Does Not Conflict With This Court's Decisions In *Travelers*, *Dillingham*, And *De Buono*

Notwithstanding all the foregoing, petitioner argues that the decision below conflicts with this Court's decisions in *Travelers*, *Dillingham*, and *De Buono*, which, petitioner argues, hold that a mere burden on a plan cannot be sufficient to establish preemption. As the Second Circuit recognized, however, those cases stand for a different principle—that ERISA does not disturb state laws of general applicability that do *not* fall within areas of core concern to ERISA merely because those laws might have an incidental economic impact on employee benefit plans. Thus, although the

Second Circuit recognized that *Travelers* "marked something of a pivot in ERISA preemption" (Pet. App. 18), it also observed that "*Travelers* and its progeny do not disturb the longstanding principle that 'state statutes that mandate[] employee benefits structures *or their administration*' have a 'connection with' ERISA plans and are therefore preempted" (Pet. App. 20 (quoting *Dillingham*, 519 U.S. at 328)).

In *Travelers*, this Court considered whether ERISA preempted a state law that required hospitals to collect surcharges on hospital bills paid by commercial insurers but not on hospital bills paid by Blue Cross and Blue Shield Plans. 514 U.S. at 649. The Court recognized that the surcharge would have an "indirect economic effect on choices made by insurance buyers, including ERISA plans" because it would make Blue Cross and Blue Shield plans more attractive than commercial insurance plans. *Id.* at 659. The Court observed, however, that an "indirect economic influence ... does not bind plan administrators to any particular choice" or "preclude uniform administrative practice." *Id.* at 659-660. The Court ultimately concluded that "laws with only an indirect economic effect on the relative costs of various health insurance packages in a given State" do not trigger preemption under ERISA. *Id.* at 662.

Dillingham involved a state prevailing wage law that allowed contractors to pay a lower-than-prevailing wage to workers participating in a state certified apprenticeship program. 519 U.S. at 319-321. The law thus provided an incentive for ERISA-covered apprenticeship programs to obtain state certification, but did not require them to do so. *Id.* at 332. The Court observed that the law did "not bind ERISA plans to anything" but "merely ... provide[d] some measure of eco-

nomic incentive to comport with the State's requirements." *Id.* Ultimately, the Court noted that the effect of the law was substantially similar to the effect of the surcharge at issue in *Travelers*, in that it "alter[ed] the incentives, but [did] not dictate the choices, facing ERISA plans." *Id.* at 334. The Court thus held that the law did not have a "connection with" ERISA plans and was not preempted by ERISA. *Id.*

In *De Buono*, the Court held that ERISA did not preempt the application of a state law "imposing a gross receipts tax on the income of medical centers" to medical centers operated by ERISA funds. 520 U.S. at 809. In doing so, the Court observed that the law was "a tax on hospitals," and that "[m]ost hospitals are not owned or operated by ERISA funds." *Id.* at 816. The Court went on to observe that "[a]ny state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute." *Id.*

Travelers, *Dillingham*, and *De Buono* stand for the proposition that state laws of general applicability that address subject areas outside an ERISA plan's core functions are not preempted merely because they might have some economic impact on ERISA plans. But that principle has no application here, because Vermont's reporting requirements do not merely have an economic impact on ERISA plans. Vermont has imposed a reporting mandate that requires the reporting of information about core ERISA activities: the payment of claims under the plan. "In other words, unlike generally applicable laws regulating areas where ERISA has nothing to say, which [this Court has] upheld notwithstanding their incidental effect of ERISA

plans," Vermont's reporting regime affects "a central matter of plan administration," *Egelhoff*, 532 U.S. at 147 (internal quotation marks and citations omitted). The court of appeals was thus correct to conclude that the *Travelers* principle does not save Vermont's requirements from preemption.

III. The Question Presented Is Not The Subject Of A Circuit Split

Petitioner also contends that the decision below is inconsistent with the Sixth Circuit's decision in *Self-Insurance Institute of America, Inc.* v. *Snyder*, 761 F.3d 631 (2014) (*SIAA*). To the contrary, there is no conflict between the two circuits on the question presented by the petition, and any supposed "disagreement" (Pet. 14) between them does not warrant this Court's review.

SIAA involved a Michigan law requiring third party administrators and "carriers," which as defined included the sponsors of group health plans set up under ERISA, to pay a one-percent tax on paid claims to health care providers. 761 F.3d at 632. Incidental to the tax, the law imposed recordkeeping requirements and required carriers and third-party administrators to submit quarterly returns to the Michigan Department of the Treasury. The Sixth Circuit held that ERISA did not preempt enforcement of the law against ERISA-covered entities. In so ruling, the Sixth Circuit compared the Michigan law to the surcharges this Court upheld in *Travelers* and *De Buono*, noting that "[t]he Act's only potential effects are to cut the plans' profits" and "to create work independent of the core functions of ERISA." *Id.* at 636.

With respect to the reporting and record-keeping requirements in the Michigan law, the Sixth Circuit observed that those requirements applied "only when the carriers compute the tax—a function entirely divorced from plan administration." 761 F.3d at 636. The Sixth Circuit also read *Travelers* and *De Buono* as implicitly approving the reporting requirements that were "essential parts of the tax schemes" at issue in those cases, and noted that ERISA does not "bar states from imposing additional administrative burdens unrelated to the plans' core functions." *Id.* at 638. The court went on to conclude that the reporting and record-keeping requirements in the Michigan law existed solely "to guarantee that the carriers pay the correct amount of tax" and that "such record-keeping requirements accompany all taxes and remain in force despite ERISA." *Id.* at 639.

The Sixth Circuit's judgment with respect to the Michigan law does not conflict with the Second Circuit's decision in this case. Unlike the record-keeping and reporting requirements in the Michigan law, Vermont's reporting requirements are related to the core functions of an ERISA plan. Whereas the requirements in the Michigan law were directed at an activity (tax payments) that did not implicate a core ERISA function, Vermont requires ERISA plans to report on their primary ERISA activity: providing plan participants with benefits.

Although petitioner makes much of language in the Sixth Circuit's decision purporting to "disagree" with the "literal approach to preemption" that the Sixth Circuit believed the Second Circuit had employed in reaching its decision below, 761 F.3d at 639, those statements in the Sixth Circuit's opinion do not warrant review of the Second Circuit's judgment. Notwithstanding any difference that the Sixth Circuit might have perceived

between the two courts' approaches to ERISA preemption, the Sixth Circuit ultimately *agreed* with the Second Circuit's conclusion that ERISA preempts Vermont's reporting requirements as applied here.

The Sixth Circuit distinguished Vermont's reporting requirements from the Michigan law it was reviewing by observing that "[t]he Vermont scheme actually affects the administration of the plans; it does not just create additional administrative work unrelated to the processing of the claims, as the [Michigan] Act involved here does." 761 F.3d at 639. The Sixth Circuit further explained that the Vermont reporting requirements would force Liberty Mutual to make an unacceptable choice on how to administer the plan. *Id.* Under the Vermont reporting requirements, Liberty Mutual must either direct Blue Cross not to comply with the requirements, which would require Liberty Mutual to indemnify Blue Cross for the ensuing civil penalties, or it must allow Blue Cross to turn over the data in violation of its plan documents. *Id.*; *see also* Pet. App. 10. The Sixth Circuit concluded that, "[u]nder our conception of the ERISA preemption provision, state laws cannot put this choice to ERISA-covered entities." 761 F.3d at 639.

The Sixth Circuit thus ultimately recognized in *SIAA* that there were fundamental differences between the Michigan law at issue there and Vermont's reporting requirements, and it suggested that Vermont's reporting requirements would be preempted under its view of ERISA preemption. This case would therefore likely have been decided the same way had it arisen in the Sixth Circuit. Accordingly, there is no conflict between the circuits warranting this Court's review.

IV. Petitioners And Amici Overstate The Impact Of The Court Of Appeals' Decision

Both petitioner and amici suggest that exempting self-insured plans from the mandatory reporting of medical claims data for use in Vermont's database threatens similar programs in other states by rendering all-payer claims databases ineffective as a tool for developing health care policy. Pet. 30; States of N.Y. et al. Amicus Br. 3, 7-8. Contrary to those claims, the Second Circuit's decision does not threaten either the existence or the effectiveness of such databases. Nor does it "cast[] a shadow over a wide range of other state regulations." Pet. 15, 26.

First, the Second Circuit's decision will not prevent states from obtaining an accurate picture of the health care services provided within their borders. In this respect, it is noteworthy that several of the states that petitioner and amici claim will be affected by the Second Circuit's decisions have not joined the amici in supporting petitioner, including Connecticut, which is within the Second Circuit. Moreover, neither the petitioner nor the amici explain why the medical claims information of participants in ERISA plans could not be readily obtained from the health care providers that service those participants. Indeed, the enabling legislation in several of the states with claims databases, including Vermont, allow for the collection of information from health care providers.[14]

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[14] *See* Pet. App. 94 (requiring '[h]ealth insurers, health care providers, health care facilities, and governmental agencies' to 'file reports, data schedules, statistics, or other information" (18 V.S.A. § 9410(c))); *see also* Kan. Stat. Ann. § 65-6805 (listing health care providers among entities that must file health care data); R.I. Code § 23-17.17-10 ("health providers ... shall file reports"); Utah

Moreover, any contention that claims databases will be unreliable absent mandatory reporting by self-insured plans is belied by the fact that not all such databases require self-funded ERISA plans to report claims information. Indeed, not all of the sixteen states that amici have identified as "creating health-care data collection programs of this type" require self-funded insurance plans to report medical claims data for use by the State.[15] And amici do not mention that, in addition to the sixteen states that they identify as having implemented health-care data collection programs, voluntary claims databases exist in several other states that do not rely on mandatory reporting requirements.[16]

Finally, there is no substance to petitioner's overwrought assertion that the Second Circuit's decision "casts a shadow over a wide range of other state regulations" and "provides a basis for challenging state health care regulations, taxes, licensing, and safety rules—all of which typically require recordkeeping and reporting of compliance information." Pet. 15. Nothing in the Second Circuit's decision provides a footing for this speculation. As already discussed, the Second Circuit did not hold Vermont's regime preempted merely

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Code Ann. § 26-33a-102 (defining "data supplier" to include health care facilities and providers).

[15] Va. Code Ann. § 32.1-276.7:1(B) ("The Commissioner ... *may* collect paid claims data for covered benefits ... from entities *electing* to participate as data suppliers." (emphasis added)).

[16] Pet. App. 7 ("Some states provide only for voluntary reporting."); C.A. App. A368-374 (identifying Louisiana, Washington, and Wisconsin as states with voluntary APCDs); *see also* All-Payer Claims Database Council data for California, http://apcdcouncil.org/state/california (last visited Nov. 6, 2014) (discussing California's voluntary database).

because it contains reporting requirements, and the court expressly recognized that not every state law imposing a reporting requirement is preempted.

In fact, the panel specifically pointed to prior Second Circuit decisions that upheld reporting requirements unrelated to core ERISA plan functions. Pet. App. 22-24. Those prior decisions involved one of the areas of state regulation—state prevailing wage laws—that petitioner now claims is under threat as a result of the decision below. *See HMI Mech. Sys., Inc.* v. *McGowan*, 266 F.3d 142 (2d Cir. 2001); *Burgio & Campofelice, Inc.* v. *New York State Dep't of Labor*, 107 F.3d 1000, 1009 (2d Cir. 1997); *cf.* Pet. 34-35 (suggesting that under the Second Circuit's decision a challenge to a prevailing wage statute could "easily be recast as objections to reporting or recordkeeping requirements"). The panel did not question those decisions; rather, it distinguished them, precisely because they are not like Vermont's law in that they do not operate in an area of core ERISA concern. Pet. App. 18-21. The court thus made clear that its decision below does not threaten ordinary state regulations that have incidental recordkeeping and reporting requirements, and petitioner's speculation that the decision will cut a wide swath through state law provides no basis for this Court's review.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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NOVEMBER 2014

APPENDICES

RELEVANT STATUTORY PROVISIONS

Vermont Statutes Annotated
Title Eight. Banking and Insurance
Part 1. General Administrative Provisions
Chapter 1. Policy and Administration
§ 13. Powers and penalties

(a) In addition to any other penalties, and in order to enforce this title, 9 V.S.A. chapters 131 and 150, Title 9A, and 18 V.S.A. chapter 221, the Commissioner may issue subpoenas, examine persons, administer oaths and require production of papers and records. Any subpoena or notice to produce may be served by registered or certified mail or in person by an agent of the Commissioner. Service by registered or certified mail shall be effective three business days after mailing. Any subpoena or notice to produce shall provide at least six business days' time from service within which to comply, except that the Commissioner may shorten the time for compliance for good cause shown. Any subpoena or notice to produce sent by registered or certified mail, postage prepaid, shall constitute service on the person to whom it is addressed. Each witness who appears before the Commissioner under subpoena shall receive a fee and mileage as provided for witnesses in civil cases in superior courts; provided, however, any person subject to regulation under this title shall not be eligible to receive fees or mileage under this section.

(b) A person who fails or refuses to appear, to testify or to produce papers or records for examination before the Commissioner, upon properly being ordered to do so, may be assessed an administrative penalty by the Commissioner of Financial Regulation of not more than $2,000.00 for each day of noncompliance and proceeded

against as provided in the Administrative Procedure Act, and that person's authority to do business may be suspended for not more than six months.

(c) If an appeal or other petition for judicial review of a final order is not filed in connection with an order of the Commissioner under this title, or 18 V.S.A. chapter 22, the Commissioner may file a certified copy of the final order with the clerk of a court of competent jurisdiction. The order so filed has the same effect as a judgment of the court and may be recorded, enforced, or satisfied in the same manner as a judgment of the court.

(d) In addition to any other penalties or powers, the Commissioner may order a person to make restitution or provide disgorgement of any sums shown to have been obtained in violation of provisions of this title and 18 V.S.A. chapter 221, plus interest at the legal rate.

STATE OF VERMONT
DEPARTMENT OF BANKING, INSURANCE, SECURITIES AND HEALTH CARE ADMINISTRATION

TO: Blue Shield of Massachusetts HMO Blue, Inc.
AND Blue Cross and Blue Shield of Massachusetts, Inc.

Docket No. 11-035-H

SUBPOENA

Pursuant to the authority contained in 8 V.S.A. §13, YOU ARE HEREBY DIRECTED TO PRODUCE to Onpoint Health Data, duly-appointed contractor of the Department of Banking, Insurance, Securities and Health Care Administration, located at 16 Association Drive, Manchester, Maine, 04351, THE INFORMATION, DATA, AND DOCUMENTS SPECIFIED IN THE ATTACHED Exhibit "A" on or before August 10, 2011 and pursuant to the instructions in Exhibit "A." The data should be submitted in the same manner as previous submissions.

The terms "information, data, and documents" include, but are not limited to, all records and other tangible forms of expression, drafts or finished versions, originals, copies of annotated copies, however produced or stored (manually, mechanically, electronically or otherwise), including but not limited to books, papers, files, notes, correspondence, memoranda, ledger sheets, reports, telegrams, telexes, facsimiles, telephone logs, contracts, agreements, calendars or date books, phone logs, bank statements, worksheets, computer files including electronic mail, software disk packs and other electronic media and the documents generated therefrom, microfilm, microfiche, and storage devices.

Pursuant to 8 V.S.A. § 13(b), a person who fails or refuses to produce papers or records for examination before the Commissioner, upon properly being ordered to do so, may be assessed an administrative penalty by the Commissioner of not more than $2,000.00 for each day of noncompliance and proceeded against as provided in the Administrative Procedure Act, and that person's authority to do business may be suspended for not more than six months.

Dated at Montpelier, Vermont this 2nd day of August, 2011.

By: /s/ S W Kimbell
STEPHEN W. KIMBELL, COMMISSIONER
Vermont Department of Banking, Insurance, Securities and Health Care Administration

EXHIBIT A

Instructions

The following files for Vermont enrollees ("the files") are due to the Vermont Department of Banking, Insurance, Securities and Health Care Administration ("the Department") to meet ongoing reporting requirements of the State's Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) as specified in State Reg. H-2008-01. The files which precede the June filing period are overdue to the Department, and the June filings are due by July 31, 2011 and must be electronically filed with Onpoint Health Data, the State of Vermont's designated contractor.

All files must meet the same filing requirements and be electronically filed in the same manner as the historic production files that have already been submitted to Onpoint Health Data by Blue Cross Blue Shield of Massachusetts, Inc. and Blue Cross Blue Shield of Massachusetts HMO Blue, Inc. for preceding filing periods.

Following production of these files, Blue Cross Blue Shield of Massachusetts, Inc. and Blue Cross Blue Shield of Massachusetts HMO Blue, Inc. are to resume timely submissions of monthly production files.

Data To Be Produced

The files are:

1. Blue Cross Blue Shield of Massachusetts, Inc.
    - Eligibility files for the following months of incurred services for 2011: April, May, June
    - Medical claims files for the following months of incurred services for 2011: January, April, May, June

- Pharmacy claims files for the following months of incurred services for 2011: April, May, June

2. Blue Cross Blue Shield of Massachusetts HMO Blue, Inc.
   - Eligibility files for the following months of incurred services for 2011: April, May, June
   - Medical claims files for the following months of incurred services for 2011: January, March, April, May, June
   - Pharmacy claims files for the following months of incurred services for 2011: April, May, June

No. 14-181

In The
Supreme Court of the United States

ALFRED J. GOBEILLE, IN HIS OFFICIAL CAPACITY AS CHAIR OF THE VERMONT GREEN MOUNTAIN CARE BOARD,

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

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ARGUMENT

The Court should grant the petition to return clarity and predictability to an area – ERISA preemption – that has a profound impact on state policies and the federal-state balance.

First, the question presented is one of undeniable national importance. Both Vermont and the amici States have explained how the decision below, if not immediately addressed by this Court, will undermine state health care policies across the nation. Pet. 26-35; Amicus Br. N.Y. et al. 4-8.

Second, the decision below conflicts with relevant decisions of this Court and has already been sharply criticized by the Sixth Circuit. Pet. 6-25; Amicus Br. N.Y. et al. 8-14. Liberty Mutual argues at length that the Second Circuit panel majority correctly interpreted this Court's ERISA preemption cases. Opp. 14-27. Conspicuously absent, however, is any mention that the U.S. Department of Labor – the federal agency charged with administering ERISA – filed an amicus brief in the Second Circuit taking the opposite position. U.S. Ct. App. Br. 5 (Vermont's law "does not relate to ERISA plans in any way that dictates benefit choices or interferes with plan administration or structure."). The federal government, seven States, another court of appeals, and the dissenting judge below all disagree with the Second Circuit's sweeping expansion of ERISA preemption. Nothing short of clarification by this Court will resolve this confusion.

Indeed, recognizing the strength of Vermont's petition on the merits, Liberty Mutual focuses instead on the unremarkable substitution of the relevant government official as petitioner. This invented jurisdictional objection should not distract from the need for this Court's immediate review. Vermont is familiar with its own laws and knows who is running the State's database. The Chair is the right party and was properly substituted under this Court's Rule 35.3.

I. As confirmed by the States' amicus brief and the participation of the United States below, this case presents an issue of exceptional importance that warrants immediate review.

The Second Circuit's broad expansion of ERISA preemption in this case undermines a critical tool that States use to improve the quality of health care for their citizens and reduce its cost. That is not just Vermont's view. The multistate amicus brief filed by New York – a State also directly impacted by the ruling below – urges this Court's review. As the amici explain, the "decision below will diminish the ability of States to improve the quality and affordability of the health-care services available to their residents." Amicus Br. N.Y. et al. 2. All told, sixteen States have or are developing all-payer claims databases to "audit the cost and effectiveness of the health care provided within their borders." *Id.* at 1. The Second Circuit's holding creates a gaping hole in those databases,

because it cuts out data for tens of millions of Americans covered by self-insured plans. Michael Brien et al., *Self-Insured Benefit Plans,* at 21.[1]

The States' interest is substantial, but so too is that of the federal government. The U.S. Department of Labor, which enforces ERISA, appeared as amicus below and argued against preemption. U.S. Ct. App. Br. 5-30. Liberty Mutual, like the Second Circuit panel majority, makes no mention of the government's position. The fact that the federal government devoted its resources to an amicus filing that supported Vermont and the district court confirms the importance of this issue. *See* Pet. App. 38-39 (Straub, J., dissenting) (relying in part on Department's position to conclude "the Vermont statute is not of the type that Congress intended to preempt"). And the fact that the federal government has voluntarily agreed to provide its claims data to Vermont shows that federal policymakers also recognize the value of comprehensive health care data.[2]

The opposition suggests that States do not need data from self-insured plans. But the States understand their own programs and policy objectives better than Liberty Mutual does. And the States' position is

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[1] Available at: http://www.dol.gov/ebsa/pdf/acaselffundedhealthplansreport032811.pdf.

[2] While this case was pending on appeal, the federal Centers for Medicare and Medicaid Services agreed to provide its claims data for Vermont's database. *See* Pet. 22 n.3.

unambiguous: omitting self-insured plans "create[s] significant and serious gaps" in the data, undermines the accuracy and "integrity" of a database, and "significantly diminish[es] the ability of States with APCD laws to regulate health care through the evidence-based approaches they have elected." Amicus Br. N.Y. et al. 7-8. Liberty Mutual cannot reasonably dispute these concerns. The majority of Americans who receive health insurance coverage from their employers are covered by self-insured plans. *See* Kaiser Family Foundation, *Employer Health Benefits 2013 Survey*, at 176.[3] An *all-payer* claims database that omits self-insured plans cannot be considered accurate or comprehensive.

With no little irony, Liberty Mutual suggests that States should rely on voluntary reporting. Liberty Mutual, with 80,000 plan members, Pet. App. 50, is not offering to report its data voluntarily. And no credible statistician would prefer a self-selected, incomplete data set to an accurate one. The States that have elected to build these databases want to see the full picture, not a jigsaw puzzle with missing pieces.

Likewise, the notion that doctors and hospitals can provide the data reflects Liberty Mutual's poor grasp of the function and design of these databases. Unlike providers, insurers and third-party administrators maintain standardized claims data. And only

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[3] Available at: http://kff.org/private-insurance/report/2013-employer-health-benefits/.

these payers can provide accurate information. Providers often do not know the final amounts paid by plans, which may reflect coordination of benefits or coverage reversals. Doctors and hospitals do not have most prescription drug claim information, which is a substantial part of health care costs.

The Court should disregard Liberty Mutual's unsupported – indeed, unscientific – position that States can do just as well with incomplete and inadequate information. One suspects that Liberty Mutual's own actuaries and economists are not so cavalier about the information they use to set insurance rates and fix reserves. The States take seriously their obligation to provide for the welfare of their citizens and have every right to seek critical information needed to support effective health care reforms.

That is why review is needed now. Accurate information is vital for rational policy-making and effective, evidence-driven health care regulation. Health care is not an issue for the future. It is a crisis today. Costs have been rising at an unsustainable rate for years. Health care spending dominates state budgets. The federal government's role in health care reform remains contested. *See King v. Burwell*, No. 14-114 (*cert. granted* Nov. 7, 2014). The States and the lower courts need clear guidance on the scope of ERISA preemption and the room States have to pursue innovative policies that serve the needs of their citizens.

II. The Second Circuit's sweeping expansion of ERISA preemption creates an urgent need for this Court's review.

Liberty Mutual's extended treatment of the merits does nothing to rebut the case for this Court's review. In fact, it does the opposite.

First, the Second Circuit's decision in this case departs so substantially from this Court's precedents that even Liberty Mutual does not defend its reasoning. Instead, Liberty Mutual re-writes the decision to avoid its undesirable consequences. It describes the ruling as limited to "reporting of information about core ERISA activities," Opp. 26, and contends that other state reporting requirements would not be affected, *id.* at 31-32. To the contrary, the majority broadly defined reporting as "plan record-keeping, and filing with a third-party," and held that ERISA tolerates only a "slight" burden on what it deemed a "core ERISA function." Pet. App. 23-24. The dissent criticized the majority for "giving the term reporting its broadest meaning." Pet. App. 32-33 (Straub, J., dissenting). Under the majority's flawed approach, any requirement that a plan keep or provide information would be at risk if a court viewed it as too "time-consuming" or more than slightly "burdensome." Pet. App. 24-25.

Liberty Mutual similarly tries to avoid the broad sweep of the Second Circuit's reasoning by positing that Vermont's reporting requirements involve "plan administration," whereas other reporting requirements

do not. But that approach, again, contradicts the Second Circuit's insistence that *all* "reporting" is a "core ERISA function." Pet. App. 23-24. Moreover, Liberty Mutual does not explain why Vermont's reporting requirement involves "plan administration" any more than other commonplace reporting requirements, including reports related to taxes paid on health care claims, *Self-Ins. Inst. of America, Inc. v. Snyder*, 761 F.3d 631, 638-39 (6th Cir. 2014) (*SIIA*);[4] reports to the regulators of health care services, *see* Pet. 32; and reports by other plan-run services like day care centers and apprenticeship programs, *see* Pet. 34.

It is not surprising that Liberty Mutual is unwilling to defend the Second Circuit's broad standard. If the mere providing of information is a core ERISA concern, then numerous state laws governing public health and safety are potentially preempted. *See* Pet. 31-35. The Second Circuit's "literal approach to preemption," *SIIA*, 761 F.3d at 639, and misplaced focus on unproven administrative burdens cannot be reconciled with this Court's precedents. Pet. 16-25; *see De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997); *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *cf. Cal. Div. Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 355 (1997) (Scalia, J., concurring) ("The statutory text

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[4] Supreme Court Docket No. 14A373 (granting extension of time to file petition).

provides an illusory test, unless the Court is willing to decree a degree of pre-emption that no sensible person could have intended."). As the Sixth Circuit explained in *SIIA*, "ERISA guarantees uniformity only with regard to the administration of employee benefit plans," and does not preempt record-keeping and reporting requirements that do not "change[ ] or interfere[ ] with plan administration." 761 F.3d at 636-39 (quotation omitted).

Second, Liberty Mutual's fourteen-page argument on the merits merely confirms the need for this Court's review. Liberty Mutual believes the lower court is correct, but it cannot change the fact that the federal government, seven States, the dissenting judge below, and the Sixth Circuit all disagree. The Second Circuit rejected without comment or explanation the considered views of the federal agency that enforces ERISA. The panel split sharply over basic matters like the application of the presumption against preemption and the purposes of ERISA's reporting provisions. *Compare* Pet. App. 18 n.8, 23-24 *with id.* at 33-34, 37-38 (Straub, J., dissenting). This uncertainty and confusion can only be resolved by this Court.

The Second Circuit's return to an unduly broad and literal understanding of ERISA preemption is a matter of grave concern to the States. Twice before, this Court has stepped in and cabined the Second Circuit's approach to ERISA preemption. *De Buono*, 520 U.S. at 812-13; *Travelers*, 514 U.S. at 653-54. The Court should do so again, and reaffirm that nothing

in ERISA "indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. at 661.

III. Vermont's routine substitution of a public official raises no jurisdictional question.

The petition was properly filed by the state official responsible for administering and enforcing the State's program. The Vermont Legislature transferred responsibility for the database, called VHCURES, from the Department of Financial Regulation to the Green Mountain Care Board, an independent state agency. *See* 2013 Vt. Acts & Resolves, No. 79 ("Act 79"), § 40 (Reply App. 25-33); Vt. Stat. Ann. tit. 18, §§ 9373, 9374. Vermont adhered to Supreme Court Rule 35.3 by substituting the Chair of the Board for the Commissioner of the Department.

Liberty Mutual's objection to this routine substitution is easily dispatched. In its complaint, Liberty Mutual seeks a declaratory judgment that the database statute and rule "are preempted by ERISA to the extent they require the reporting, production, or disclosure" of information by the plan. Reply App. 16. Liberty Mutual also seeks a permanent injunction against future enforcement. *Id.* at 17. Given these requests for prospective relief, the official that presently administers and enforces the statute is the proper defendant.

The Board Chair is that defendant. Act 79 leaves no doubt that the Legislature transferred both administrative responsibility and enforcement authority to the Board. The word "commissioner" is crossed out and replaced by "Board" at least twenty-two times in the relevant section. Act 79, § 40 (Reply App. 25-33). The Board is given authority over reporting requirements and confidentiality standards. *Id.* (amending § 9410(d), (f), (h), (j)(2)). Staffing and funding were shifted to the Board, with the former administrative division abolished. *Id.* §§ 50(a), 52(e) (Reply App. 33-34). Rulemaking power now rests with the Board. *Id.* § 40 (amending § 9410(j)(2)) (Reply. App. 32) ("The ~~commissioner~~ Board may adopt rules. . . ."). And the Board has taken over enforcement authority for the database, including authority to impose financial penalties for violations of the statute. *See id.* (amending § 9410(g) (Reply App. 28-29). That power is "in addition to," *id.*, the Board's general subpoena power. *See* Vt. Stat. Ann. tit. 18, § 9374(i)-(j) (Reply App. 23-24); *id.* § 9412 (additional powers).

Given the Legislature's comprehensive transfer of authority to the Board, Liberty Mutual's objection to the substitution of the Chair as petitioner is baseless. This Court's Rule 35.3 – nearly identical to Fed. R. Civ. P. 25(d) and Fed. R. App. P. 43(c)(2) – provides that "[w]hen a public officer who is a party to a proceeding in this Court in an official capacity dies, resigns, or otherwise ceases to hold office, the action does not abate and any successor in office is automatically substituted as a party." Sup. Ct. R. 35.3. As

Liberty Mutual acknowledges, Opp. 11 n.4, the substitution rule applies "when a particular function is transferred from one office to another office." 7C C. Wright et al., Federal Practice and Procedure § 1960 (2014); *see Top Flight Entm't, Ltd. v. Schuette*, 729 F.3d 623, 630 n.1 (6th Cir. 2013) (recognizing automatic substitution of state official after transfer of authority); *Air Line Pilots Ass'n v. Civil Aeronautics Bd.*, 750 F.2d 81, 87, 89 (D.C. Cir. 1984) (transfer between federal agencies); *cf. Wright v. Council of Emporia*, 407 U.S. 451, 458 n.10 (1972) (noting district court had treated city officials as "successors" to county officials in school desegregation case).

Because substitution is automatic, the Chair had no obligation to intervene, and it makes no difference that the caption was not amended below. *See* Opp. 13 & nn.6-7. When the law changed, the Chair was "substituted automatically . . by operation of" the rule. *Schuette,* 729 F.3d at 630 n.1. "[N]o consequences follow from the failure to enter" an order of substitution. 7C C. Wright et al., Federal Practice and Procedure § 1960; *see* Sup. Ct. R. 35.3 ("any misnomer not affecting substantial rights of the parties will be disregarded").

While Liberty Mutual suggests that "relevant" enforcement authority was not transferred, Opp. 12, all it has shown is that the subpoena directed to its third-party administrator in 2011 was issued by the Commissioner. Of course it was, because that was the Commissioner's role in 2011. And of course the Legislature did not remove the Commissioner's general

subpoena power (Vt. Stat. Ann. tit. 8, § 13(b)) when it transferred the database to the Board. The Commissioner still needs, and still has, subpoena power for other purposes, but she does not oversee the database or enforce the reporting obligation.[5]

What matters for purposes of the automatic substitution rule is not what happened in 2011, but what would happen now. And now, the Board, not the Commissioner, would enforce compliance with the database statute and regulation. The Chair has authority to issue subpoenas, compel production of documents, and sanction a party's failure to comply. Vt. Stat. Ann. tit. 18, § 9374(i)-(j) (Reply App. 23-24) (conferring subpoena power and authorizing fines for noncompliance); *id.* tit. 3, § 809a (court enforcement of subpoenas). The Legislature gave the Board

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[5] Liberty Mutual makes two points about the Commissioner's subpoena power, neither of which are relevant. First, Liberty Mutual suggests that the Chair does not have the "same" power as the Commissioner to sanction noncompliance, Opp. 12, but fails to mention that the Chair has identical authority to impose fines and seek court enforcement of subpoenas. *Compare* Vt. Stat. Ann. tit. 18, § 9374(j) (Chair may impose penalty up to $2,000.00 per day, seek court enforcement, and recommend license suspension) *with id.* tit. 8, § 13(b) (same, except Commissioner may suspend "authority to do business"). Second, while the Commissioner's subpoena statute lists, among other provisions, the statutory chapter (Chapter 221) that includes the database, the Commissioner has *other* responsibilities in that chapter. *See, e.g., id.* tit. 18, § 9414a (health insurers' annual reports). The Commissioner's Chapter 221 authority is, moreover, limited to "the execution of all laws vested in the Department by this chapter." *Id.* § 9404(a).

express authority to impose monetary penalties for violations of the database statute. *Id.* tit. 18, § 9410(g) (Pet. App. 95). The fact that the 2011 subpoena was not issued by the Board is irrelevant, because enforcement of the 2011 subpoena is not "at the core of this dispute." Opp. 10. Liberty Mutual challenges any prospective enforcement against its plan. That is what the complaint says. Reply App. 16-17. And that is what Liberty Mutual requested below: "remand with instructions that the district court enter a declaratory judgment that ERISA preempts the Vermont Statute and Regulation to the extent that they require the Plan's claims data to be reported to Vermont." Liberty Mutual Ct. App. Br. 41. The relief sought by Liberty Mutual could no longer be entered against the Commissioner.

A complaint filed today would name the Chair as the defendant. That alone confirms that the Chair is the proper party. And Liberty Mutual surely knows this. The change to Vermont law was plain and the party substitution routine. Liberty Mutual has invented a jurisdictional objection. That it did so, and led with this weak argument as its principal objection to the petition, can only be explained as an effort to distract attention from the merits.

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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UNITED STATES DISTRICT COURT
DISTRICT OF VERMONT

Liberty Mutual Insurance Company Plaintiff, v. Stephen W. Kimbell, in his capacity as the Vermont Commissioner of Banking, Insurance, Securities and Health Care Administration, Defendant.	)	2:11-cv-204

VERIFIED COMPLAINT FOR DECLARATORY JUDGMENT AND OTHER RELIEF

(Filed Aug. 12, 2011)

Plaintiff Liberty Mutual Insurance Company ("Liberty Mutual"), through its undersigned attorneys, for its verified complaint against defendant Stephen W. Kimbell ("Defendant") in his capacity as the Vermont Commissioner of Banking, Insurance, Securities and Health Care Administration ("BISHCA"), states as follows:

JURISDICTION AND VENUE

1. This is an action pursuant to the Declaratory Judgment Act, 28 U.S.C. § 2201, *et seq.* and the Employee Retirement Income Security Act of 1974

("ERISA"), 29 U.S.C. § 1001 *et seq.* This case involves an actual controversy between the parties as to whether ERISA preempts a state statute and regulation requiring the disclosure to BISHCA of confidential health care information and records of medical treatment provided to private individuals in Vermont.

2. This Court has subject matter jurisdiction under both ERISA Section 502(e)(1), which provides the Court with exclusive jurisdiction to hear suits under Section 502(a)(3), and 28 U.S.C. § 1331.

3. Venue in this Court is proper under Section 502(e)(2) of ERISA because this is the District where the threatened violation of ERISA will take place and because the Defendant resides or may be found in this District.

PARTIES

4. Plaintiff Liberty Mutual is an insurance company organized under the laws of the Commonwealth of Massachusetts. Liberty Mutual is a wholly owned subsidiary of Liberty Mutual Group Inc. Liberty Mutual's principal offices are located at 175 Berkeley Street, Boston, Massachusetts 02116. Liberty Mutual has employees and offices in Vermont and conducts business in Vermont.

5. Defendant Stephen W. Kimbell is Commissioner of BISHCA for the State of Vermont, and is named as Defendant in that capacity. Pursuant to Vermont statutory authority, BISHCA has promulgated

Regulation H-2008-01 ("Regulation"), which generally requires that private health care data and records of individuals' medical treatment be provided to BISHCA. The Regulation is intended to implement the creation of a "unified health care data base" pursuant to 18 V.S.A. § 9410. The Regulation states that it was "issued pursuant to the authority vested in the Commissioner of" BISHCA.

BACKGROUND AND FACTS

A. Liberty Mutual's ERISA-Governed Employee Welfare Benefit Plan and Its Third Party Administrator

6. Approximately 54 years ago, Liberty Mutual established the Liberty Mutual Medical Plan (the "Plan") for the benefit of its employees. The Plan provides a broad range of medical care benefits to Liberty Mutual's employees and their beneficiaries. As of June 30, 2011, the Plan provides medical benefits to 84,711 persons throughout the United States, including 32,933 employees of Liberty Mutual Group Inc. and its subsidiaries, as well as employees' families and company retirees. Of these people, 137 are in Vermont, including all company employees in Vermont and their families. Liberty Mutual does not offer the right to participate in the Plan to a Vermont resident unless such individual is an employee of Liberty Mutual Group Inc., or one of its participating subsidiaries, a qualifying family member of such an employee, or an eligible company retiree.

7. The Plan is an employee welfare benefit plan governed by ERISA. *See* ERISA Section 3(1), codified at 29 U.S.C. § 1002(1). Liberty Mutual was at all times relevant hereto a "named fiduciary" and "plan administrator" of the Plan within the meaning of Section 3 of ERISA, 29 U.S.C. § 1002. Liberty Mutual Group Inc. is the "Plan Sponsor" within the meaning of Section 3 of ERISA, 29 U.S.C. § 1002.

8. The Plan provides medical benefits that are self-insured by Liberty Mutual Group Inc., meaning that Liberty Mutual Group Inc. pays all benefits provided under the Plan from its own general assets. Blue Cross Blue Shield of Massachusetts, Inc. ("BCBSMA" or the "TPA") is the Plan's third party administrator, and it administers the medical claims and associated confidential medical records of Plan participants and beneficiaries. BCBSMA is also in possession of, and on an ongoing basis continues to receive, confidential and private medical data and records involving Plan participants and beneficiaries.

B. The Pertinent ERISA Provisions

9. ERISA is a comprehensive federal statute that regulates private employee benefit plans in order to provide protection to plan participants and beneficiaries. *See Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 209 (2002); http://www.dol.gov/dol/topic/health-plans/erisa.htm (last visited August 11, 2011). One of the primary purposes of ERISA is to provide for the "uniform national treatment" of

employee benefit plans. *Arnold v. Lucks,* 392 F.3d 512, 519 (2d Cir. 2004) (citing *Yates Profit Sharing Plan v. Hendon,* 124 S. Ct. 1330, 1331 (2004)).

10. "ERISA expressly preempts 'any and all State laws insofar as they may now or hereafter relate to any employee benefit plan' covered by the statute." *Geller v. County Line Auto Sales, Inc.,* 86 F.3d 18, 22 (2d Cir. 1996) (citations omitted). "The express preemption provisions of ERISA are deliberately expansive. . . . [and] are among the broadest that can be found in the law." *Id.*

11. Section 404 of ERISA governs how fiduciaries of ERISA-governed plans are to behave. *See generally* ERISA § 504, codified at 29 U.S.C. § 1104. Section 404(a)(1)(A) of ERISA provides that a plan fiduciary, like Liberty Mutual, "shall discharge his duties with respect to a plan *solely in the interest of the participants and beneficiaries* and . . . *for the exclusive purpose* of (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan." ERISA § 404(a)(1)(A), codified as 29 U.S.C. § 1104(a)(1)(A) (emphasis added). Accordingly, ERISA forbids Liberty Mutual, a Plan fiduciary, from using the Plan for any purpose other than to provide benefits to Plan participants and beneficiaries.

12. In addition, ERISA provides "detailed reporting and disclosure requirements." *Massachusetts v. Morash,* 490 U.S. 107, 118 (1999); *see* 29 U.S.C. §§ 1023-1030. Part 1 of Subtitle B of ERISA sets forth

the reporting and disclosure duties of an administrator of a large employee welfare benefit plan such as the Plan. These requirements include publishing an annual report that is filed with the Secretary of Labor. *See* Section 103 of ERISA The annual report sets forth identifying information regarding the plan, the number of participants, the plan's funding arrangement and the plan's benefit arrangement. The annual report does not require any disclosure of the confidential, individualized health care and medical claims information sought by BISHCA. *See* ERISA Section 106, codified at 29 U.S.C. § 1026. Section 502(c)(2) of ERISA and the regulations thereunder set forth the penalties for failure to comply with ERISA's annual reporting requirements.

13. ERISA makes clear that the United States Department of Labor is the entity Congress contemplated and authorized to collect and analyze data regarding ERISA health plans. Section 513 of ERISA expressly gives the Secretary of Labor "authori[ty] to undertake research and surveys and in connection therewith to collect, compile, analyze and publish data, information, and statistics relating to . . . welfare plans" such as the Plan. 29 U.S.C. § 1143(a). ERISA does not provide the States with authority to collect data from ERISA plans, but rather vests that authority in the Department of Labor.

14. Despite its considerable breadth, ERISA preemption does not extend to state laws that regulate only insurance, banking, or securities. *See* ERISA § 514(b)(2)(A), codified at 29 U.S.C. § 1144(b)(2)(A).

This exception to the general rule of ERISA preemption is known as the "Savings Clause." Under the Savings Clause, states are generally permitted to enact laws regulating only insurance. *See id.*

15. The "Deemer Clause" was also included in Section 514 of ERISA to ensure that the Savings Clause was not used as an end-run around ERISA's sweeping preemption provision. *See* ERISA § 514(b)(2)(B), codified at 29 U.S.C. § 1144(b)(2)(B). The Deemer Clause provides that a self-funded plan shall not "be deemed to be an insurance company . . . or to be engaged in the business of insurance . . . for purposes of any state law purporting to regulate" insurance businesses. *Id.* The Deemer Clause makes clear that a state law will not avoid ERISA preemption by merely deeming an employee benefit plan to be an insurer.

16. Nothing in ERISA permits a State to deem a self-insured employee welfare benefit plan or those providing administrative services to such a plan to be an insurance company so that it can require reporting of confidential, personal medical information to create its own proprietary health care database.

C. BISHCA and the Regulation

17. BISHCA is a Vermont state agency which, according to its website, "provid[es] a single point of access for consumer complaint resolution, enforcement authority, and legislative contact on issues affecting financial and health care services in Vermont."

http://www.bishca.state.vt.us/ (last visited Aug. 7, 2011). The Division of Health Care Administration, one of BISHCA's divisions, "regulates and monitors key sectors of Vermont's health care system to ensure that all Vermonters have access to health care that is affordable and meets accepted standards for quality." http://www.bishca.state.vt.us/health-care/health-care-administration (last visited Aug. 9, 2011). The Defendant is the Commissioner of BISHCA.

18. The state of Vermont has enacted 18 V.S.A. § 9410 (the "Statute") in its effort to regulate heath care administration. The Statute calls for BISHCA to create a "unified health care database," so that the Commissioner of BISHCA can carry out certain duties. *See* 18 V.S.A. § 9410(a)(1). These duties include: 1) determining the capacity and distribution of existing resources; 2) identifying health care needs and informing health care policy; 3) evaluating the effectiveness of intervention programs on improving patient outcomes; 4) comparing costs between various treatment settings and approaches; 5) providing information to consumers and purchasers of health care; and 6) improving the quality and affordability of patient health care and health care coverage. *See* 18 V.S.A. § 9410(a)(1)(A)-(F). These goals have nothing to do with regulating insurance but are, instead, directly aligned with the stated mission of BISHCA's Division of Health Care Administration. BISHCA is also granted enforcement responsibilities under the Statute.

19. Pursuant to the Statute, BISHCA promulgated Regulation H-2008-01 (the "Regulation") to implement the creation of a "unified health care data base." The Regulation states that "[t]he purpose of this rule is to set forth the requirements for the *submission of health care claims data, member eligibility data, and other information relating to health care* provided to Vermont residents or by Vermont health care providers and facilities by health insurers, managed care organizations, *third party administrators,* pharmacy benefit managers and others to [BISHCA] . . . and conditions for the use and dissemination of such claims data . . consistent with the purposes of 18 V.S.A. § 9410." *See* Regulation Section 1 (emphasis added).

20. In furtherance of this purpose, the Regulation requires "Health Insurers" to "regularly submit *medical claims data, pharmacy claims data, member eligibility data, provider data, and other information relating to health care* provided to Vermont residents and health care provided by Vermont health care providers and facilities to both Vermont residents and non residents in specified electronic format to [BISHCA]." *See* Regulation Section 4(A) (emphasis added).

21. The Regulation broadly defines "Health Insurer" to include any "third party administrator . . . and any entity conducting administrative services for business or possessing claims data, eligibility data, provider files, and other information relating to health care provided to Vermont residents or by

Vermont health care providers and facilities. The term may also include . . . any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities." *See* Regulation § 3(X). By its terms, the definition includes plan administrators, like Liberty Mutual, and third party administrators, like BCBSMA.

22. Accordingly, the Regulation requires Liberty Mutual and BCBSMA to annually report the Plan's private health care data and records of individuals' medical treatment to BISHCA.

D. The Issuance of the BISHCA Subpoena

23. BISHCA has repeatedly attempted to apply the Statute and Regulation to Liberty Mutual's ERISA-governed Plan. BISHCA has recently made several demands that Liberty Mutual and BCBSMA report the Plan's medical claims data. The information sought includes Plan participants' and beneficiaries' name, gender, date of birth, city zip code, social security number, diagnosis and procedure code, type of bill paid, amount charged, the co-payment or coinsurance amount, and drug code, among other information. *See* Regulation, at Appendix C-1.

24. In late May 2011, BCBSMA informed Liberty Mutual that BISHCA was being "very aggressive" in its efforts to enforce the claims data reporting Regulation and was pressuring BCBSMA to report the claims data for Liberty Mutual's Plan.

25. Both Liberty Mutual and BCBSMA have made numerous attempts to persuade BISHCA to abandon its efforts to apply the Regulation to the Plan. On June 6, 2011, Mary Connolly, the Vice President of Benefits at Liberty Mutual, and Liberty Mutual's Counsel Nancy L. Keating, spoke with Clifford Peterson, General Counsel for the Health Care Division of BISHCA, regarding the Vermont reporting rules and the issue of ERISA preemption. During that discussion, Mr. Peterson indicated that BISHCA would likely take enforcement action against BCBSMA if it failed to report the individual medical records and data of Plan participants and beneficiaries in the precise manner demanded by BISHCA. Liberty Mutual requested that BISHCA reconsider its insistence that the TPA report confidential health care information and participant medical records.

26. Subsequently, Jack Myers of BCBSMA communicated to Ms. Connolly that BISCHA "was about to take imminent action against" BCBSMA if it failed to submit the specific information, records and data demanded by BISCHA regarding Plan participants and beneficiaries.

27. On July 29, 2011, Ms. Connolly and Ms. Keating again spoke to BISHCA General Counsel Clifford Peterson and informed him that Liberty Mutual would continue to instruct BCBSMA not to report the claims data to BISHCA as it was inconsistent with the requirements of ERISA, and BISHCA had no right to compel a self-insured medical plan to

disclose confidential health care information so BISHCA could create a health care database, because the Regulation was preempted by ERISA. Mr. Peterson responded that ERISA did not preempt the Vermont reporting rules.

28. Subsequently, on August 5, 2011, the Defendant served a subpoena on BCBSMA and Blue Cross Blue Shield of Massachusetts HMO Blue, Inc.[1] (the "Subpoena"). *See* Exhibit A.

29. The Subpoena demands that the TPA produce "Eligibility files for the following months of incurred service for 2011: April, May, June"; "Medical claim files for the following months of incurred service for 2011: January, April, May, June"; and "Pharmacy claim files for the following months of incurred service for 2011: April, May, June." The data demanded in the Subpoena includes personal identifying information regarding individual Plan participants' and beneficiaries' medical treatment, including Plan member name, gender, date of birth, city zip code, social security number, diagnosis and procedure code, type of bill paid, amount charged, co-payment or coinsurance amount, and drug code, among other items of information.

30. The Subpoena states that "*the files which precede the June filing period are overdue to the*

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[1] Blue Cross Blue Shield of Massachusetts HMO Blue, Inc. does not provide services to the Plan, nor has the Plan provided medical records or data to that entity.

Department, and the June filings are due by July 31, 2011." (emphasis added).

31. The Subpoena further states that "[p]ursuant to 8 V.S.A. § 13(b), a person who fails or refuses to produce papers or records . . . *may be assessed a penalty by the Commissioner of not more than $2,000.00 for each day* of noncompliance and proceeded against as provided in the Administrative Procedure act, and that person's *authority to do business may be suspended* for not more than six months." (emphasis added).

E. The Controversy Between the Parties

32. Liberty Mutual, as the Plan administrator, has repeatedly resisted BISHCA's attempt to require the reporting or other disclosure of the confidential information, records, and data of Plan participants and beneficiaries, for three primary reasons.

33. First, the Statute and Regulation are preempted by ERISA. Specifically, the Statute and Regulation impose a new reporting regime on self-funded medical plans that requires reporting and disclosure different in kind and in scope from what is imposed under ERISA. As such, the Statute and Regulation are an attempt to intrude upon the uniform and exclusive regulation of employee benefit plans that Congress provided under ERISA. BISHCA has attempted to avoid ERISA's preemptive effect by defining "Health Insurers" to include plan administrators and third party administrators. However, this

is nothing more than a legal fiction designed to allow BISHCA to improperly seek the confidential health care information, private medical records, and data of the Plan's participants and beneficiaries. Significantly, ERISA's Deemer Clause expressly rejects states' attempts to classify employee benefit plans as insurance companies in order to regulate them. BISHCA's attempt to treat Liberty Mutual and BCBSMA as "health insurers" is further belied by the fact that no Vermont resident without ties to Liberty Mutual Group Inc. and its subsidiaries can purchase insurance under the Plan.

34. Second, providing the Plan's claims data to BISHCA under the Statute and Regulation could constitute a violation of Liberty Mutual's ERISA fiduciary duties. The duties outlined in Section 404 of ERISA compel Liberty Mutual to safeguard against the type of detailed and intrusive reporting regime being imposed by BISHCA, particularly because BISHCA may release claims data to various third parties who request such data. *See* Regulation Section 9. Quite simply, the Plan may not be administered at the expense of the Plan and its participants in order to develop a health care database so that the State of Vermont can best determine how health care should be provided to residents.

35. Third, the Plan owns the claims data that BISHCA seeks, and Liberty Mutual Group Inc. and its subsidiaries, as a national employer, has designed the Plan to meet its own competitive needs in the marketplace. Accordingly, BISHCA is not entitled to

information related to the Plan design, including which claims the Plan does and does not cover or what a member's required coinsurance or copayments may be under the Plan, nor is it entitled to information relating to a participant's confidential medical claims information. BISHCA is similarly not entitled to compel the Plan's service providers (like BCBSMA) to report such information, irrespective of whether that individual is or is not a Vermont resident, since the service providers have no right to release the data to BISHCA without Liberty Mutual's consent.

COUNT I
ERISA Section 502(a)(3)

36. Plaintiff re-alleges and incorporates by reference all preceding allegations in this Complaint as though fully set forth in this Count I.

37. Section 502(a)(3) of ERISA provides that "[a] civil action may be brought . . . by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan."

38. There exists an actual controversy between Liberty Mutual and Defendant, which controversy can be resolved by a judgment of this Court.

39. Defendant subpoenaed the TPA demanding it turn over confidential health care information and

private medical records and data of Liberty Mutual's Plan participants and beneficiaries, and threatening the TPA with substantial fines and loss of its ability to do business in Vermont if it does not comply with the subpoena. The TPA has indicated that absent preliminary injunctive relief from this Court, the TPA will be forced to, and will, comply with the Subpoena and turn over the medical records and data being demanded.

40. Liberty Mutual, as Plan administrator and named fiduciary, therefore sues under Section 502(a)(3) of ERISA seeking a declaratory judgment and to enjoin Defendant's attempt to force the TPA to produce the subpoenaed information because Defendant's actions, and the Regulation and 18 V.S.A. § 9410, each violate and are preempted by ERISA.

41. Plan participants and beneficiaries who are Vermont residents, as well as the Plan and its fiduciaries, will suffer irreparable harm if enforcement of the Subpoena is not preliminarily and permanently enjoined.

WHEREFORE, Liberty Mutual respectfully requests that this Court:

A. Declare that BISHCA' s Regulation H-2008-01 and the Vermont health care database statute set forth in 18 V.S.A. § 9410 are preempted by ERISA to the extent they require the reporting, production, or disclosure of any confidential health care information or medical records or data relating to the Plan or its participants and beneficiaries;

B. Preliminarily and permanently enjoin the Defendant from attempting to obtain, from the TPA or any other source, any medical records or data relating to the Plan or its participants and beneficiaries;

C. Award Liberty Mutual its reasonable attorney's fees and costs incurred in this action pursuant to ERISA Section 502(g); and

D. Grant such further equitable relief as may be deemed appropriate.

Dated: August 12th 2011 Respectfully submitted,

/s/ R. Jeffrey Behm

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VERIFICATION

I, Mary Connolly, have reviewed the allegations made in this Verified Complaint and swear and affirm under penalties of perjury of the laws of the United States of America that they are true and correct to the best of my knowledge and belief.

/s/ Mary Connolly
Mary Connolly
Vice President &
Manager of Benefits
Liberty Mutual
Insurance Company

Subscribed and sworn to
before me this 12 day of
August, 2011

/s/ Jeanne Morse
Notary Public [Notary Stamp]

EXHIBIT A

STATE OF VERMONT
DEPARTMENT OF BANKING, INSURANCE, SECURITIES AND HEALTH CARE ADMINISTRATION

TO: Blue Shield of Massachusetts HMO Blue, Inc. AND Blue Cross and Blue Shield of Massachusetts, Inc.	))))	Docket No. 11-035-H

SUBPOENA

Pursuant to the authority contained in 8 V.S.A. §13, YOU ARE HEREBY DIRECTED TO PRODUCE to *Onpoint Health Data,* duly-appointed contractor of the Department of Banking, Insurance, Securities and Health Care Administration, located at 16 Association Drive, Manchester, Maine, 04351, THE INFORMATION, DATA, AND DOCUMENTS SPECIFIED IN THE ATTACHED EXHIBIT "A" on or before *August 10, 2011* and pursuant to the instructions in Exhibit "A." The data should be submitted in the same manner as previous submissions.

The terms "information, data, and documents" include, but are not limited to, all records and other tangible forms of expression, drafts or finished versions, originals, copies of annotated copies, however produced or stored (manually, mechanically, electronically or otherwise), including but not limited to books, papers, files, notes, correspondence, memoranda, ledger sheets, reports, telegrams, telexes,

facsimiles, telephone logs, contracts, agreements, calendars or date books, phone logs, bank statements, worksheets, computer files including electronic mail, software disk packs and other electronic media and the documents generated therefrom, microfilm, microfiche, and storage devices.

Pursuant to 8 V.S.A. § 13(b), a person who fails or refuses to produce papers or records for examination before the Commissioner, upon properly being ordered to do so, may be assessed an administrative penalty by the Commissioner of not more than $2,000.00 for each day of noncompliance and proceeded against as provided in the Administrative Procedure Act, and that person's authority to do business may be suspended for not more than six months.

Dated at Montpelier, Vermont this 2nd day of August, 2011.

By: /s/ S. W. Kimbell
STEPHEN W KIMBELL,
COMMISSIONER
Vermont Department of
Banking, Insurance,
Securities and Health
Care Administration

EXHIBIT A

Instructions

The following files for Vermont enrollees ("the files") are due to the Vermont Department of Banking,

Insurance, Securities and Health Care Administration ("the Department") to meet ongoing reporting requirements of the State's Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) as specified in State Reg. H-2008-01. The files which precede the June filing period are overdue to the Department, and the June filings are due by July 31, 2011 and must be electronically filed with Onpoint Health Data, the State of Vermont's designated contractor.

All files must meet the same filing requirements and be electronically filed in the same manner as the historic production files that have already been submitted to Onpoint Health Data by Blue Cross Blue Shield of Massachusetts, Inc. and Blue Cross Blue Shield of Massachusetts HMO Blue, Inc. for preceding filing periods.

Following production of these files, Blue Cross Blue Shield of Massachusetts, Inc. and Blue Cross Blue Shield of Massachusetts HMO Blue, Inc. are to resume timely submissions of monthly production files.

Data To Be Produced

The files are:

1. Blue Cross Blue Shield of Massachusetts, Inc.
    - Eligibility files for the following months of incurred services for 2011: April, May, June

- Medical claims files for the following months of incurred services for 2011: January, April, May, June
- Pharmacy claims files for the following months of incurred services for 2011: April, May, June

2. Blue Cross Blue Shield of Massachusetts HMO Blue, Inc.

- Eligibility files for the following months of incurred services for 2011: April, May, June
- Medical claims files for the following months of incurred services for 2011: January, March, April, May, June
- Pharmacy claims files for the following months of incurred services for 2011: April, May, June

Title 18: Health

Chapter 220: GREEN MOUNTAIN CARE BOARD

Sub-Chapter 001: Green Mountain Care Board

18 V.S.A. § 9374. Board membership; authority

§ 9374. Board membership; authority

* * *

(i) In addition to any other penalties and in order to enforce the provisions of this chapter and empower the Board to perform its duties, the Chair of the Board may issue subpoenas, examine persons, administer oaths, and require production of papers and records. Any subpoena or notice to produce may be served by registered or certified mail or in person by an agent of the Chair. Service by registered or certified mail shall be effective three business days after mailing. Any subpoena or notice to produce shall provide at least six business days' time from service within which to comply, except that the Chair may shorten the time for compliance for good cause shown. Any subpoena or notice to produce sent by registered or certified mail, postage prepaid, shall constitute service on the person to whom it is addressed. Each witness who appears before the Chair under subpoena shall receive a fee and mileage as provided for witnesses in civil cases in Superior Courts; provided, however, any person subject to the Board's authority shall not be eligible to receive fees or mileage under this section.

(j) A person who fails or refuses to appear, to testify, or to produce papers or records for examination before the Chair upon properly being ordered to do so may be assessed an administrative penalty by the Chair of not more than $2,000.00 for each day of noncompliance and proceeded against as provided in the Administrative Procedure Act, and the Chair may recommend to the appropriate licensing entity that the person's authority to do business be suspended for up to six months.

No. 79. An act relating to health insurance, Medicaid, the Vermont Health Benefit Exchange, and the Green Mountain Care Board.

(H.107)

It is hereby enacted by the General Assembly of the State of Vermont:

* * *

Sec. 40. 18 V.S.A. § 9410 is amended to read:

§ 9410. HEALTH CARE DATABASE

(a)(1) The ~~commissioner~~ *Board* shall establish and maintain a unified health care database to enable the ~~commissioner and the Green Mountain Care board~~ *Commissioner and the Board* to carry out their duties under this chapter, chapter 220 of this title, and Title 8, including:

(A) ~~Determining~~ *determining* the capacity and distribution of existing resources.;

(B) ~~Identifying~~ *identifying* health care needs and informing health care policy.;

(C) ~~Evaluating~~ *evaluating* the effectiveness of intervention programs on improving patient outcomes.;

(D) ~~Comparing~~ *comparing* costs between various treatment settings and approaches.;

(E) ~~Providing~~ *providing* information to consumers and purchasers of health care.; *and*

(F) ~~Improving~~ *improving* the quality and affordability of patient health care and health care coverage.

(2)(A) The program authorized by this section shall include a consumer health care price and quality information system designed to make available to consumers transparent health care price information, quality information, and such other information as the ~~commissioner~~ *Board* determines is necessary to empower individuals, including uninsured individuals, to make economically sound and medically appropriate decisions.

(B) ~~The commissioner shall convene a working group composed of the commissioner of mental health, the commissioner of Vermont health access, health care consumers, the office of the health care ombudsman, employers and other payers, health care providers and facilities, the Vermont program for quality in health care, health insurers, and any other individual or group appointed by the commissioner to advise the commissioner on the development and implementation of the consumer health care price and quality information system~~.

~~(C)~~ The ~~commissioner~~ *Commissioner* may require a health insurer covering at least five percent of the lives covered in the insured market in this state to file with the ~~commissioner~~ *Commissioner* a consumer health care price and quality information plan in accordance with rules adopted by the ~~commissioner~~ *Commissioner*.

~~(D)~~*(C)* The ~~commissioner~~ *Board* shall adopt such rules as are necessary to carry out the purposes of this subdivision. The ~~commissioner's~~ *Board's* rules may permit the gradual implementation of the consumer health care price and quality information system over time, beginning with health care price and quality information that the ~~commissioner~~ *Board* determines is most needed by consumers or that can be most practically provided to the consumer in an understandable manner. The rules shall permit health insurers to use security measures designed to allow subscribers access to price and other information without disclosing trade secrets to individuals and entities who are not subscribers. The ~~regulations~~ *rules* shall avoid unnecessary duplication of efforts relating to price and quality reporting by health insurers, health care providers, health care facilities, and others, including activities undertaken by hospitals pursuant to their community report obligations under section 9405b of this title.

(b) The database shall contain unique patient and provider identifiers and a uniform coding system, and shall reflect all health care utilization, costs, and resources in this ~~state~~ *State*, and health care utilization and costs for services provided to Vermont residents in another ~~state~~ *State*.

(c) Health insurers, health care providers, health care facilities, and governmental agencies shall file reports, data, schedules, statistics, or other information determined by the ~~commissioner~~ *Board*

to be necessary to carry out the purposes of this section. Such information may include:

(1) health insurance claims and enrollment information used by health insurers;

(2) information relating to hospitals filed under subchapter 7 of this chapter (hospital budget reviews); and

(3) any other information relating to health care costs, prices, quality, utilization, or resources required *by the Board* to be filed ~~by the commissioner~~.

(d) The ~~commissioner~~ *Board* may by rule establish the types of information to be filed under this section, and the time and place and the manner in which such information shall be filed.

(e) Records or information protected by the provisions of the physician-patient privilege under 12 V. S.A. § 1612(a), or otherwise required by law to be held confidential, shall be filed in a manner that does not disclose the identity of the protected person.

(f) The ~~commissioner~~ *Board* shall adopt a confidentiality code to ensure that information obtained under this section is handled in an ethical manner.

(g) Any person who knowingly fails to comply with the requirements of this section or rules adopted pursuant to this section shall be subject to an administrative penalty of not more than $1,000.00 per violation. The ~~commissioner~~ *Board* may impose an

administrative penalty of not more than $10,000.00 each for those violations the ~~commissioner~~ *Board* finds were willful. In addition, any person who knowingly fails to comply with the confidentiality requirements of this section or confidentiality rules adopted pursuant to this section and uses, sells, or transfers the data or information for commercial advantage, pecuniary gain, personal gain, or malicious harm shall be subject to an administrative penalty of not more than $50,000.00 per violation. The powers vested in the ~~commissioner~~ *Board* by this subsection shall be in addition to any other powers to enforce any penalties, fines, or forfeitures authorized by law.

(h)(1) All health insurers shall electronically provide to the ~~commissioner~~ *Board* in accordance with standards and procedures adopted by the ~~commissioner~~ *Board* by rule:

(A) their health insurance claims data, provided that the ~~commissioner~~ *Board* may exempt from all or a portion of the filing requirements of this subsection data reflecting utilization and costs for services provided in this ~~state~~ State to residents of other states;

(B) cross-matched claims data on requested members, subscribers, or policyholders; and

(C) member, subscriber, or policyholder information necessary to determine third party liability for benefits provided.

(2) The collection, storage, and release of health care data and statistical information that is subject to the federal requirements of the Health Insurance Portability and Accountability Act ("HIPAA") shall be governed exclusively by the ~~rules~~ *regulations* adopted thereunder in 45 ~~CFR~~ *C.F.R.* Parts 160 and 164.

(A) All health insurers that collect the Health Employer Data and Information Set (HEDIS) shall annually submit the HEDIS information to the ~~commissioner~~ *Board* in a form and in a manner prescribed by the ~~commissioner~~ *Board*.

(B) All health insurers shall accept electronic claims submitted in Centers for Medicare and Medicaid Services format for UB-92 or HCFA-1500 records, or as amended by the Centers for Medicare and Medicaid Services.

(3)(A) The ~~commissioner~~ *Board* shall collaborate with the ~~agency of human services~~ *Agency of Human Services* and participants in ~~agency of human services~~ *the Agency's* initiatives in the development of a comprehensive health care information system. The collaboration is intended to address the formulation of a description of the data sets that will be included in the comprehensive health care information system, the criteria and procedures for the development of ~~limited use~~ *limited-use* data sets, the criteria and procedures to ensure that HIPAA compliant ~~limited use~~ *limited-use* data sets are accessible, and a proposed time frame for the creation of a comprehensive health care information system.

(B) To the extent allowed by HIPAA, the data shall be available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in Vermont. In presenting data for public access, comparative considerations shall be made regarding geography, demographics, general economic factors, and institutional size.

(C) Consistent with the dictates of HIPAA, and subject to such terms and conditions as the ~~commissioner~~ *Board* may prescribe by ~~regulation~~ rule, the Vermont ~~program for quality in health care~~ *Program for Quality in Health Care* shall have access to the unified health care database for use in improving the quality of health care services in Vermont. In using the database, the Vermont ~~program for quality in health care~~ *Program for Quality in Health Care* shall agree to abide by the rules and procedures established by the ~~commissioner~~ *Board* for access to the data. The ~~commissioner's~~ *Board's* rules may limit access to the database to limited-use sets of data as necessary to carry out the purposes of this section.

(D) Notwithstanding HIPAA or any other provision of law, the comprehensive health care information system shall not publicly disclose any data that contains direct personal identifiers. For the purposes of this section, "direct personal identifiers" include information relating to an individual that contains primary or obvious identifiers, such as the

individual's name, street address, e-mail address, telephone number, and Social Security number.

(i) On or before January 15, 2008 and every three years thereafter, the ~~commissioner~~ *Commissioner* shall submit a recommendation to the ~~general assembly~~ *General Assembly* for conducting a survey of the health insurance status of Vermont residents.

(j)(1)) As used in this section, and without limiting the meaning of subdivision 9402(8) of this title, the term "health insurer" includes:

(A) any entity defined in subdivision 9402(8) of this title;

(B) any third party administrator, any pharmacy benefit manager, any entity conducting administrative services for business, and any other similar entity with claims data, eligibility data, provider files, and other information relating to health care provided to *a* Vermont resident, and health care provided by Vermont health care providers and facilities required to be filed by a health insurer under this section;

(C) any health benefit plan offered or administered by or on behalf of the ~~state~~ *State* of Vermont or an agency or instrumentality of the ~~state~~ *State*; and

(D) any health benefit plan offered or administered by or on behalf of the federal government with the agreement of the federal government.

(2) The ~~commissioner~~ *Board* may adopt rules to carry out the provisions of this subsection, including

~~standards and procedures requiring the registration of persons or entities not otherwise licensed or registered by the commissioner and~~ criteria for the required filing of such claims data, eligibility data, provider files, and other information as the ~~commissioner~~ *Board* determines to be necessary to carry out the purposes of this section and this chapter.

* * *

Sec. 50. TRANSFER OF POSITIONS

(a) On or before July 1, 2013, the Department of Financial Regulation shall transfer positions numbered 290071, 290106, and 290074 and associated funding to the Green Mountain Care Board for the administration of the health care database.

(b) On or before July 1, 2013, the Department of Financial Regulation shall transfer position number 297013 and associated funding to the Agency of Administration.

(c) On or after July 1, 2013, the Department of Financial Regulation shall transfer one position and associated funding to the Department of Health for the purpose of administering the hospital community reports in 18 V.S.A. § 9405b. The Department of Financial Regulation shall continue to collect funds for the publication of the reports pursuant to 18 V.S.A. § 9415 and shall transfer the necessary funds annually to the Department of Health.

* * *

Sec. 52. REPEALS

(a) 8 V.S.A. § 4080f (Catamount Health) is repealed on January 1, 2014, except that current enrollees may continue to receive transitional coverage from the Department of Vermont Health Access as authorized by the Centers on Medicare and Medicaid Services.

(b) 18 V.S.A. § 708 (health information technology certification process) is repealed on passage.

(c) 33 V.S.A. chapter 19, subchapter 3a (Catamount Health Assistance) is repealed January 1, 2014, except that current enrollees may continue to receive transitional coverage from the Department of Vermont Health Access as authorized by the Centers for Medicare and Medicaid Services.

(d) 33 V.S.A. § 2074 (VermontRx) is repealed on January 1, 2014.

(e) 18 V.S.A. § 9403 (Division of Health Care Administration) is repealed on July 1, 2013.

(f) 8 V.S.A. § 4089w (Health Care Ombudsman) is repealed on January 1, 2014.

* * *

AMICUS CURIAE BRIEF

Supreme Court, U.S.
FILED
MAY 19 2015
OFFICE OF THE CLERK

No. 14-181

In the Supreme Court of the United States

ALFRED GOBEILLE, IN HIS OFFICIAL CAPACITY AS CHAIR OF THE VERMONT GREEN MOUNTAIN CARE BOARD, PETITIONER

v.

LIBERTY MUTUAL INSURANCE COMPANY

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.*, preempts, as applied to self-insured health benefit plans or their third-party administrators, a Vermont statute that requires healthcare payers to report claims and healthcare-services data to a state agency.

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No. 14-181

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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

INTEREST OF THE UNITED STATES

This brief is submitted in response to the order of this Court inviting the Solicitor General to express the views of the United States. In the view of the United States, the petition for a writ of certiorari should be denied.

STATEMENT

1. The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, is designed to "protect * * * the interests of participants in employee benefit plans and their beneficiaries * * * by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C.

1001(b). The statute requires every plan to be established and maintained pursuant to a written instrument and to have named fiduciaries who have authority to control and manage the administration of the plan and its assets. 29 U.S.C. 1102(a)(1), 1103(a). With specific exceptions, ERISA preempts "any and all State laws insofar as they * * * relate to any employee benefit plan" covered by the statute. 29 U.S.C. 1144(a).

Various provisions of ERISA impose reporting requirements on plans. Plan administrators generally must file detailed financial and actuarial information with the Secretary of Labor (Secretary). See 29 U.S.C. 1021(b), 1023, 1024(a). In addition, plan administrators must file reports with the Secretary when certain events occur, such as when a pension plan winds up its affairs, 29 U.S.C. 1021(c), or when the employer fails to make a payment required under ERISA's minimum funding standard, 29 U.S.C. 1021(d). Under 29 U.S.C. 1024(a)(3), however, the Secretary has exempted welfare plans from most reporting requirements. See 29 C.F.R. 2520.103-1, 2520.104-20, 2520.104-44. Only when a welfare plan's assets are held in trust must it provide the Secretary with financial information. 29 C.F.R. 2520.103-1.

In addition, the Secretary has broad authority to investigate health plans for enforcement purposes. See 29 U.S.C. 1132(a)(5) (authority to enforce statutory provisions or enjoin violations); 29 U.S.C. 1134 (authority to investigate). Such investigations typically entail the inspection of plan documents, administrative contracts, and claims records to determine whether breaches of fiduciary duty or violations of the claims-processing rules have occurred or whether a

plan is out of compliance with other legal requirements. ERISA also authorizes the Secretary "to undertake research and surveys and in connection therewith to collect, compile, analyze and publish data, information, and statistics relating to employee benefit plans." 29 U.S.C. 1143(a)(1).[1]

2. a. A Vermont statute requires the Green Mountain Care Board (Board), a state agency, to maintain a healthcare-information database. Vt. Stat. Ann. tit. 18, § 9402(17) (2012), *id.* § 9410(a) (Supp. 2014) (Database Statute). The database is designed to help the state government achieve a variety of health-policy objectives, including "identifying health care needs," "comparing costs between various treatment settings and approaches," "determining the capacity and distribution of existing resources," and "providing information to consumers and purchasers of health care." *Id.* § 9410(a)(1) (Supp. 2014).

The Database Statute requires "[h]ealth insurers" and other entities to submit to the Board "reports, data, schedules, statistics, or other information" that the Board finds necessary. § 9410(c)-(d) (Supp. 2014). In particular, it authorizes the Board to require health insurers to file "health insurance claims and enrollment information" and "any other information relating to health care costs, prices, quality, utilization, or resources." *Id.* § 9410(c)(1) and (3) (Supp. 2014). The Board is authorized to enforce the Database Statute

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[1] The Secretary has informed this Office that, in aid of his authority to ensure compliance with ERISA's fiduciary standards and claims-processing rules, the Secretary is currently considering undertaking a rulemaking to require health plans to report more detailed information about the cost of benefits, utilization of medical services, and plan administration.

through the imposition of financial penalties, *id.* § 9410(g) (Supp. 2014), and through its general subpoena power, Vt. Stat. Ann. tit. 18, § 9374(i) (Supp. 2014); *id.* § 9412(a) (2012).

In 2008, the Commissioner of the Vermont Department of Banking, Insurance, Securities and Health Care Administration (Commissioner), who had authority to enforce the Database Statute until June 7, 2013, promulgated a regulation to implement the statute. See Reg. H-2008-01, 21-040-021 Vt. Code R. (2008) (Database Regulation); see also 2013 Vt. Acts & Resolves 724-727 (transferring authority to administer statute to the Board). The Database Regulation provides that "[h]ealth insurers shall regularly submit medical claims data, pharmacy claims data, member eligibility data, provider data, and other information." § 4(D). It includes requirements for how the data must be formatted and when it must be submitted, as well as confidentiality protections. *Id.* §§ 5-8. The Database Regulation defines "[h]ealth insurer" to include any "third party administrator" and "to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities." *Id.* § 3(X). It exempts health insurers with fewer than 200 enrolled or covered members from the reporting requirements (although they may voluntarily comply). *Id.* § 3(Ab) and (As).

b. Respondent is the named fiduciary and administrator of an ERISA self-insured health plan covering 80,000 individuals, 137 of whom are Vermont residents. Pet. App. 7, 50. A self-insured plan is one in which the plan sponsor pays claims out of its own assets, rather than contracting with an insurance

company to pay claims under an insurance policy. *Id.* at 7. Self-insured plans may be administered by a third party, however, and respondent has contracted with Blue Cross Blue Shield of Massachusetts, Inc. (Blue Cross) to serve as the plan's third-party administrator in Vermont. In that capacity, Blue Cross handles administrative functions such as claims processing, bill review, and claims payments. *Id.* at 8, 50-51.

In August 2011, the Commissioner issued a subpoena to Blue Cross, seeking eligibility information and medical- and pharmacy-claims files for Vermont residents covered by respondent's plan. Pet. App. 8-9. Respondent, believing that the request was preempted by ERISA, instructed Blue Cross not to comply with the subpoena. *Id.* at 9.

3. Respondent filed suit in the United States District Court for the District of Vermont against the Commissioner.[2] Pet. App. 48. Respondent sought a declaratory judgment that the Database Statute and Database Regulation "are preempted by ERISA to the extent they require the reporting, production, or disclosure of any confidential health care information or medical records or data relating to [respondent's health benefit] [p]lan or its participants and beneficiaries." Cert. Reply Br. App. 16. Respondent also sought to enjoin the Commissioner "from attempting to obtain, from [Blue Cross] or any other source, any medical records or data relating to the [p]lan or its participants and beneficiaries." *Id.* at 17.

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[2] Vermont's Department of Banking, Insurance, Securities, and Health Care Administration was renamed the Department of Financial Regulation in 2012. 2012 Vt. Acts & Resolves 57; see Pet. App. 49 n.1.

The Commissioner moved to dismiss the complaint for lack of standing and, alternatively, on the merits. D. Ct. Doc. 15, at 1 (Sept. 15, 2011). Respondent moved for summary judgment. D. Ct. Doc. 35 (June 25, 2012). Respondent argued generally that, due to their asserted complexity, the Vermont reporting requirements impose burdens on the administration of its ERISA plan, but respondent did not submit any affidavits describing or quantifying the alleged burdens. See D. Ct. Docs. 35-37 (June 25, 2012).

The district court concluded that respondent had sufficiently alleged standing but granted the Commissioner's motion to dismiss on the merits and denied respondent's motion for summary judgment. Pet. App. 48-80. The court held that although "[c]ompliance with the reporting requirements * * * may have some indirect effect on health benefit plans," the possible "effect is so peripheral that the regulation cannot be considered an attempt to interfere with the administration or structure of a welfare benefit plan." *Id.* at 78. The court emphasized that respondent had "not submitted any information about any actual burden suffered by itself or [Blue Cross] in producing this information." *Id.* at 73 n.5.

4. Respondent appealed. The Acting Secretary of Labor filed an amicus brief in favor of the Commissioner in the court of appeals, arguing that ERISA does not preempt the Database Statute or Database Regulation. In a divided decision, the court of appeals reversed, holding that the Vermont reporting requirements are preempted. Pet. App. 1-47.[3]

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[3] Every member of the panel agreed that respondent has standing. See Pet. App. 9-10; *id.* at 30 (Straub, J., dissenting in part and concurring in part).

a. The court of appeals began by explaining that under this Court's construction of ERISA's preemption provision, 29 U.S.C. 1144(a), "a state law is preempted if 'it [1] has a connection with or [2] reference to [an ERISA] plan.'" Pet. App. 14 (brackets in original) (quoting *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)). The court of appeals further explained, however, that this Court has made clear that the preemption provision's "relate to" requirement cannot be read literally, because "if the phrase 'were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course.'" *Id.* at 19 (quoting *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 655 (1995) (*Travelers*)). The court of appeals understood this Court's decisions to teach that "'state statutes that mandate[] employee benefit structures *or their administration*' have a 'connection with' ERISA plans and are therefore preempted." *Id.* at 20 (brackets in original) (quoting *California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A.*, 519 U.S. 316, 328 (1997) (*Dillingham*)).

Applying those principles, the court of appeals held that "the reporting requirements of the Vermont statute and regulation have a 'connection with' ERISA plans (though no 'reference to' them)" and are therefore preempted. Pet. App. 23 (footnote omitted). Although the court cautioned that "[n]ot every state law imposing a reporting requirement is preempted," *id.* at 24, it determined that "the reporting mandated by the Vermont statute and regulation is burdensome, time-consuming, and risky," *id.* at 25. The court noted that Vermont could change the requirements at any

time, *id.* at 27, and it postulated that if respondent were subject to "one of several or a score of uncoordinated state reporting regimes," the burden would be "obviously intolerable," *id.* at 25.[4]

b. Judge Straub dissented in relevant part. Pet. App. 30-47 (dissenting in part and concurring in part). Adopting the view of the Acting Secretary's amicus brief, he concluded that the Vermont reporting requirements do not have a sufficient "connection with" ERISA plans to fall under the preemption provision. *Id.* at 47. Judge Straub explained that in analyzing the preemption issue, "[t]he distinction between general administration and administration of plans, claims, and benefits is important." *Id.* at 42. "Many state laws," he continued, "may have an impact on the administration of an ERISA plan—for example, a work-place safety law, a prevailing wage law, or a law that requires companies to report employment data." *Ibid.* Although "[s]uch laws may impose additional costs," he concluded, "none of these laws impact *how benefits are administered to beneficiaries* and, therefore, they are not preempted by ERISA." *Ibid.* (citing *Dillingham*, 519 U.S. at 319). Judge Straub also found that "on the record before [the court,]" no basis existed to conclude that the Vermont reporting requirements would "hinder the national administration of employment benefit plans in any way," because

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[4] The court of appeals had no occasion to address whether its holding applies to insurance companies that insure ERISA plans. ERISA generally exempts from its preemption provision "any law of any State which regulates insurance, banking, or securities." 29 U.S.C. 1144(b)(2)(A); see *Kentucky Ass'n of Health Plans, Inc.* v. *Miller*, 538 U.S. 329, 341-342 (2003).

"[n]o new records need be kept" to comply with the reporting obligation. *Id.* at 44; see *id.* at 41-42.

5. Approximately one month before the court of appeals issued its decision, a Vermont statute transferred the responsibilities for administering the reporting requirements from the Commissioner to the Chair of the Board. See p. 4, *supra*. The Commissioner did not file a motion for substitution of parties in the court of appeals, see Fed. R. App. P. 43(c)(2), and she subsequently filed a petition for rehearing, which was denied, Pet. App. 81-82. The Chair of the Board, however, filed the petition for a writ of certiorari in this Court. The petition states that the Chair was automatically substituted for the Commissioner under Rule 35.3 of the Rules of this Court. See Pet. ii.

DISCUSSION

The court of appeals erred in holding that the Vermont reporting requirements that respondent challenges are preempted by ERISA. Moreover, with the encouragement of the federal government, other States are establishing similar healthcare databases to help improve health outcomes for their citizens, and thus the question presented has national importance. But the decision of the court of appeals does not conflict with any decision of this Court or another court of appeals, and this Court's consideration of the question would likely be aided by further percolation in the courts of appeals. Accordingly, the petition for a writ of certiorari should be denied.

1. As a threshold matter, petitioner, the Chair of the Board, is an appropriate party to seek certiorari review in this case. The Chair assumed the relevant responsibilities for administering the Database Statute on June 7, 2013. See 2013 Vt. Acts & Resolves

724-727 (transferring authority to administer statute to Board). Respondent seeks prospective relief in the form of a declaratory judgment that enforcement of the reporting requirements against petitioner is preempted by ERISA and an injunction barring any attempt to "obtain, from [Blue Cross] or any other source, any medical records or data relating to the Plan or its participants and beneficiaries." Cert. Reply Br. App. 16-17.[5] Because the Chair of the Board now administers the reporting requirements and is the state official who seeks to enforce respondent's compliance with those requirements with respect to the subpoena in this case and would enforce its requirements in the future, prospective relief would properly run against the Chair, not the Commissioner.

Respondent appears to argue (Br. in Opp. 10-13) that because the subpoena that prompted this case was issued under the Commissioner's general subpoena power (at a time when the Commissioner administered the Database Statute), the Board's power to enforce the Database Statute is not at issue. But the Chair of the Board also has a general subpoena power, see Vt. Stat. Ann. tit. 18, § 9374(i)-(j) (Supp. 2014); *id.* § 9412(a) (2012), and there is no question that, going forward, the Board would invoke its own subpoena power to enforce the Database Statute and Database Regulation. See Cert. Reply Br. 11-13. The gravamen of the challenge here concerns the obligations imposed

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[5] The court of appeals characterized the injunctive relief sought by respondent as relating only to the subpoena issued to Blue Cross. See Pet. App. 9. The complaint, however, seeks an injunction against any enforcement of the reporting requirements for records or data relating to respondent's plan. See Cert. Reply Br. App. 17.

by the Database Statute and Database Regulation, not the particular source of subpoena authority. Accordingly, petitioner is correct that the Chair of the Board is the proper party to defend Vermont's reporting requirements at this point in the proceedings.[6]

2. ERISA does not preempt the Database Statute or Database Regulation.

a. ERISA's preemption provision, 29 U.S.C. 1144(a), provides that the statute "shall supersede any and all State laws insofar as they * * * relate to any employee benefit plan" covered by the statute. *Ibid.* This Court has long held that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983) (footnote omitted); see, *e.g.*, *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 656 (1995).

A law has a "reference to" ERISA plans if the law "acts immediately and exclusively upon ERISA plans" or "the existence of ERISA plans is essential to the law's operation." *California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A.*, 519 U.S. 316, 325-326 (1997). Barring such a reference, the Court "look[s] both to 'the objectives of the ERISA statute as a guide to the scope of the state law that

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[6] Supreme Court Rule 35.3 does not by its terms provide for automatic substitution in the situation in which statutory authority has been transferred from one government official to another. For that reason, it may have been the wiser course for petitioner to file a motion for substitution of parties in the court of appeals or in this Court. If this Court concludes that a motion is necessary, it could treat the petition for a writ of certiorari as encompassing such a motion.

Congress understood would survive,' as well as to the nature of the effect of the state law on ERISA plans," to "determine whether [the] state law has the forbidden connection" with ERISA plans. *Egelhoff* v. *Egelhoff ex rel. Breiner*, 532 U.S. 141, 147 (2001) (quoting *Dillingham*, 519 U.S. at 325). Where a state law unrelated to the basic purposes of ERISA operates in an area of traditional state regulation, such as "matters of health and safety," the fact that the law will have "some effect on the administration of ERISA plans" is insufficient for preemption, *De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814, 816 (1997), particularly if the state law merely "alters the incentives, but does not dictate the choices, facing ERISA plans," *Dillingham*, 519 U.S. at 334.

b. Under the foregoing standards, the Vermont reporting requirements are not preempted. Respondent does not contest the court of appeals' holding that the requirements lack any "reference to" ERISA plans. Pet. App. 23 & n.9. The requirements apply to "all health care payers," not only to ERISA plans. *Id.* at 23 n.9. And the requirements could readily operate independently of the existence of ERISA plans (although excluding ERISA plans would render Vermont's database less comprehensive). See *Dillingham*, 519 U.S. at 326.

Accordingly, as the court of appeals correctly held, the key question in this case is whether the Vermont reporting requirements have the requisite "connection with" ERISA plans. In the view of the United States, Judge Straub was correct that, at least on the record before the court of appeals, the panel majority erred in holding that such a connection exists. That conclu-

sion follows both from the significant difference between the purpose of the Database Statute and ERISA's reporting requirements and from the lack of any record evidence that the Vermont statute will have more than an incidental effect on respondent's administration of its plan or its ability to comply with ERISA's requirements.

As discussed above, ERISA imposes a number of reporting requirements on plans, such as the submission of financial and actuarial information to the Secretary. See pp. 2-3, *supra*. Those requirements serve the basic purposes of ERISA: to prevent the "mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds." *Dillingham*, 519 U.S. at 326-327 (quoting *Massachusetts* v. *Morash*, 490 U.S. 107, 115 (1989)). Any state-law reporting requirements serving the same functions would raise a substantial preemption question. Cf. *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 12-13 & n.7 (1987) (discussing *Standard Oil Co.* v. *Agsalud*, 633 F.2d 760 (9th Cir. 1980), summarily aff'd, 454 U.S. 801 (1981)). That is because such requirements would effectively alter the balance that Congress struck between, on the one hand, accountability and disclosure, and, on the other hand, administrative costs and complexity. See *Boggs* v. *Boggs*, 520 U.S. 833, 844 (1997) ("States are not free to change ERISA's structure and balance.").

The Vermont reporting requirements, however, have an entirely different focus. As the court of appeals explained, the information submitted to the Board enables it to populate a database that is designed as a tool to assess and improve healthcare

outcomes for Vermont residents. See Pet. App. 4-5 (citing Vt. Stat. Ann. tit. 18, § 9410(a)(1) (Supp. 2014)). The reporting requirements have nothing to do with ERISA's principal concerns with the soundness of plans and the actions of plan fiduciaries in administering plans and paying promised benefits. They are therefore "quite remote from the areas with which ERISA is expressly concerned." *Dillingham*, 519 U.S. at 330. For that reason, absent more, they do not fall within ERISA's preemptive scope. As this Court has explained, "in the field of health care, * * * there is no ERISA preemption without [a] clear manifestation of congressional purpose." *Pegram* v. *Herdich*, 530 U.S. 211, 237 (2000) (citing *Travelers*, 514 U.S. at 654-655).

The court of appeals nevertheless believed that the Database Statute and Database Regulation have the forbidden "connection with" ERISA plans because they require "reporting of health claims, pharmacy claims, *etc.*, information about the essential functioning of employee health plans." Pet. App. 29 n.13. But the mere fact that a state-law reporting obligation encompasses information about the operation of an ERISA plan does not suffice for preemption. In *De Buono*, for example, this Court held that a gross-receipts tax on patient services provided by a hospital operated by an ERISA plan was not preempted, see 520 U.S. at 809-810, 816, even though the administration of the tax required the hospital to file quarterly reports about its taxable gross receipts, see U.S. Amicus Br. at 2-3, *De Buono*, *supra* (No. 95-1594). The principal inquiry under the "connection with" prong of the ERISA preemption test is whether a state law "implicates an area of core ERISA concern." *Egel-*

hoff, 532 U.S. at 147. The fact that some information relevant to the operation of an ERISA plan is also relevant to non-ERISA areas of state legislative concern does not broaden the scope of ERISA preemption to include reporting requirements that have nothing to do with the financial soundness of ERISA plans or with their federal-law obligation to pay promised benefits.

That is not to say that *any* reporting obligation unrelated to the basic objectives of ERISA falls outside the scope of ERISA's preemption provision. As petitioner correctly acknowledges (Pet. 21), a state-law reporting obligation could in theory have effects on the administration of an ERISA plan that are "so acute," *De Buono*, 520 U.S. at 816 n.16, that preemption is warranted. See *Travelers*, 514 U.S. at 668; see also Br. in Opp. 19-20 & n.9. Moreover, in considering the effects of a state-law requirement, a court must consider the effects of a potential patchwork of state laws imposing different requirements, as the court of appeals held. See Pet. App. 29; see also *Egelhoff*, 532 U.S. at 149-150.

But in the posture of this case, no sound basis exists to conclude that the Vermont reporting requirements affect the administration of ERISA plans in a qualitatively different or more substantial way than "myriad state laws in areas traditionally subject to local regulation," such as health and safety, "which Congress could not possibly have intended to eliminate." *Travelers*, 514 U.S. at 668. As Judge Straub explained, "[o]n the record before [the court of appeals], there is no basis to find that the Vermont statute would cause [respondent] to increase its costs more than a *de* [*minimis*] amount to cover the cost of

sending information to the state, much less that it would cause a fiduciary to change a plan in any way." Pet. App. 40-41 (dissenting in part and concurring in part).

Respondent contends (Br. in Opp. 20) that the court of appeals' view of the burdens created by the reporting requirements "reflects a common sense assessment of the administrative realities of ERISA plans," because reporting requirements like the ones at issue here "require ERISA plans to provide states with specific information in a prescribed format and at prescribed intervals on every claim processed by the plans" and thus "directly affect those activities." But that supposition is not obvious without any factual support. If the plan has the necessary information readily at hand, for example, it is unlikely that merely reporting it to a state agency will significantly interfere with plan administration. Similarly, if Blue Cross already has procedures in place to submit the reports on behalf of other plans that Blue Cross insures or administers, it may entail little additional cost or administrative burden in submitting reports for respondent's plan. See Pet. App. 73 n.5 (noting that Blue Cross apparently provides the data on behalf of other plans).

In any event, as respondent acknowledges (Br. in Opp. 26), a state law that merely adds administrative costs to an ERISA plan is not preempted. After all, ordinary tax and employment laws can entail substantial administrative costs. To be preempted, the law must interfere with the way in which the plan is administered—for example, by requiring plan administrators to "familiarize themselves with state statutes" in order to determine to whom to pay benefits,

Egelhoff, 532 U.S. at 148-149. Without any showing that the requirements here have such an effect, the court of appeals was wrong to conclude that they are preempted.

c. Respondent briefly argues (Br. in Opp. 22-23) that the Database Statute and Database Regulation conflict with ERISA's requirement that fiduciaries follow plan documents, 29 U.S.C. 1104(a)(1)(D), because the plan documents in this case required respondent and Blue Cross to maintain the confidentiality of the medical records of participants and beneficiaries. See *Boggs*, 520 U.S. at 841 (holding that a state law is preempted by ERISA if it "conflicts with the provisions of ERISA or operates to frustrate its objects" regardless of Section 1144(a)'s applicability). But this Court has never suggested that the mere fact that a state law could conflict with a plan term is sufficient for preemption, and such a rule would effectively allow plan sponsors to evade any state law merely by adding a contrary plan term. See, *e.g.*, *FMC Corp.* v. *Holliday*, 498 U.S. 52, 54, 56-65 (1990) (analyzing whether ERISA preempted state law barring plan provision under the normal ERISA preemption framework rather than holding it preempted by Section 1104(a)(1)(D)). Respondent cites *Egelhoff*, 532 U.S. at 151 n.4, but the Court's only point in the cited discussion was that a state law that directly regulates the administration of a plan (there, the payment of benefits) is not saved from preemption if it permits a plan sponsor to expressly opt out of the law by amending plan language. That principle has no application here.[7]

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[7] In any event, the Vermont statute mandates that confidential information be "filed in a manner that does not disclose the identi-

3. Although the court of appeals erred in holding that the Vermont reporting requirements are preempted by ERISA, this Court's review of the question presented is not warranted at this time. The decision below does not squarely conflict with a decision of another court of appeals, and further percolation in the courts of appeals would likely aid this Court's ultimate review of the preemption issue.

a. Petitioner generally argues throughout the petition that the decision below conflicts with this Court's ERISA preemption decisions. Although the United States agrees that the court of appeals misapplied those general principles to the particular context of the recordkeeping requirements at issue here (see pp. 11-17, *supra*), that misapplication does not rise to the level of a direct conflict with this Court's precedent that would warrant review. This Court, in fact, has not considered a state law similar to the Vermont scheme.

Similarly, petitioner's contention (Pet. 14, 25, 31) that "[t]he Second Circuit embraced an expansive view of ERISA preemption" overstates the error of the court of appeals. The court made clear that it did

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ty of the protected person"; prohibits public disclosure of "direct personal identifiers," including names, addresses, and Social Security numbers; and requires submitters to comply with the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936. Database Statute § 9410(e) and (h)(3) (Supp. 2014). The federal Centers for Medicare and Medicaid Services provide Medicare claims data to Vermont for its database on the condition that Vermont protect the privacy of the information. See Pet. 22 n.3.

not believe that all reporting requirements would be preempted, see Pet. App. 24, and the court emphasized what it saw as the particularly burdensome nature of the requirements here, see *id.* at 25-29. Although the United States agrees with petitioner that the court of appeals lacked factual support for that conclusion, the decision below does not purport to rest on a significant expansion of ERISA preemption principles.

b. Petitioner also briefly contends (Pet. 32-33; Cert. Reply Br. 7-8) that the decision below conflicts with the Sixth Circuit's decision in *Self-Insurance Institute of America, Inc.* v. *Snyder*, 761 F.3d 631 (2014), petition for cert. pending, No. 14-741 (filed Dec. 18, 2014) (*Self-Insurance Institute*). In *Self-Insurance Institute*, the Sixth Circuit held that the application to ERISA plans of a Michigan tax on claims paid by, among others, ERISA plans to healthcare providers for services rendered was not preempted. See *id.* at 633, 641. The tax required the plans to submit quarterly returns to the state tax authority and to keep certain records. *Id.* at 633. The Sixth Circuit held that the tax law did not have the requisite "connection with" ERISA plans because the law did "not require a plan administrator to change how it administers the plan at all" but rather merely "create[d] work independent of the core functions of ERISA—as do permissible state property and employment laws." *Id.* at 635-636.

With respect to the Michigan law's recordkeeping requirements in particular, the Sixth Circuit held that although "Congress intended ERISA to preempt state laws providing for additional oversight with regard to the solvency of ERISA plans," that "basic conclu-

sion * * * does not mean that Congress intended federal law to bar states from imposing additional administrative burdens unrelated to the plans' core functions." 761 F.3d at 637-638. The Sixth Circuit pointed to *Travelers* and *De Buono* as decisions of this Court that upheld state laws that included record-keeping requirements. See *id.* at 638; see also p. 14, *supra*. And it noted that the contrary view would mean that "ERISA would preempt any state laws requiring ERISA-covered entities to submit income-tax returns, property-tax returns, or employment records." 761 F.3d at 638.

The Sixth Circuit rejected the plaintiff's reliance on the Second Circuit's decision in this case, characterizing the Second Circuit's analysis as a "literal approach" that swept too broadly. 761 F.3d at 639. But the Sixth Circuit also "distinguished" the decision below "on two other grounds." *Ibid.* First, the court said, the Michigan law's "reporting requirements are intimately related to a state tax—a traditional area of state concern that [courts] presume Congress left untouched"—whereas "the Vermont statute mandates reporting to build a healthcare database, a purpose," the court believed, that is "not entitled to the presumption." *Ibid.* Second, in the Sixth Circuit's view, the Vermont scheme "actually affects the administration of [ERISA] plans" because it requires an ERISA plan to choose between directing a third-party administrator to turn over records in violation of a plan document or to indemnify the administrator for violating state law. *Ibid.*

Although some tension exists between the analysis of the decision below and that of *Self-Insurance Institute*, that tension does not amount to a square conflict

warranting this Court's immediate review. The Sixth Circuit took pains to distinguish the decision below, and thus if a state law similar to Vermont's came before the Sixth Circuit, the State could not rely on *Self-Insurance Institute* as significant support for non-preemption. Indeed, the Sixth Circuit's opinion, if anything, seems to suggest that the result of the decision below was correct because "[t]he Vermont scheme actually affects the administration of the plans." 761 F.3d at 639. Although the United States disagrees with that dicta, it demonstrates that no square conflict exists over the question presented at this time.

c. The question presented is important, but in our view it does not require this Court's review at the present time, before any other court of appeals has had the opportunity to address a similar reporting scheme.

As petitioner explains (Pet. 26-31), the development of state healthcare claims databases has great potential to improve healthcare outcomes nationally.[8] For example, the federal Center for Medicare and Medicaid Innovation, which supports the development and testing of new healthcare payment and service-delivery models, funds a variety of state-conducted models, including models for "all payers," that rely on state data-collection efforts for evaluation purposes.

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[8] See, *e.g.*, Ctrs. For Medicare & Medicaid Servs., *Rate Review Cycle III Funding Opportunity: Frequently Asked Questions*, http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rr-foa-faq-6-6-2013.html (last visited May 19, 2015); Ctrs. For Disease Control & Prevention, *CDC's Assessment Initiative Cooperative Agreement: New Hampshire*, http://www.cdc.gov/ai/states/nh.html (last visited May 19, 2015).

See 42 U.S.C. 1315a(a)(1) and (b)(2)(B). In evaluating a model, the Secretary of Health and Human Services (HHS) must analyze "the quality of care furnished under the model, * * * [and] the changes in spending under [Medicare, Medicaid and the Children's Health Insurance Program (CHIP)] by reason of the model." 42 U.S.C. 1315a(b)(4). In part because models may sometimes shift costs among different payers or have health effects that are not reflected in the Medicare, Medicaid, and CHIP databases, it is essential to the accuracy of some evaluations to be able to analyze state-level databases that include all payer claims. According to HHS, using incomplete data sets often impedes the government's ability to assess whether initiatives have achieved cost savings or improved quality. Relatedly, Congress, recognizing the importance of access to comprehensive claims data for healthcare evaluation purposes, has made Medicare data available to States that use claims data "to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use." 42 U.S.C. 1395kk.

Although federally created health claims databases exist for Medicare and federal employees, no federal agency has created an all-payer database that encompasses ERISA-covered plans along with other payers. For that reason, States are uniquely positioned to improve quality of care and to control costs through the collection and publication of claims data. If States are unable to acquire such data from self-insured ERISA healthcare plans, their databases will be significantly less comprehensive and thus not as useful in developing health policy at both the state and national

levels. See Pet. 29-30; Sec'y of Labor C.A. Amicus Br. 10; see also States Cert. Amicus Br. 3.

Although the question presented thus has substantial importance to the Nation's healthcare system, further percolation of the question presented among the courts of appeals is likely to prove helpful to the Court. In addition to furnishing the perspective of other courts of appeals on the legal issue, additional appellate decisions in this area may furnish this Court with more information to assess the impact of similar reporting requirements on the administration of ERISA plans generally. And because States in the First, Fourth, Sixth, Eighth, Ninth, and Tenth Circuits "have enacted legislation creating health-care data collection programs" similar to Vermont's scheme (States Cert. Amicus Br. 1 & n.3), it is reasonably likely that other circuits will have the opportunity to consider the question presented.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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No. 14-181

IN THE

Supreme Court of the United States

ALFRED GOBEILLE, IN HIS OFFICIAL CAPACITY AS CHAIR OF THE VERMONT GREEN MOUNTAIN CARE BOARD,

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE STATES OF NEW YORK, MARYLAND, MASSACHUSETTS, NEW HAMPSHIRE, OREGON, AND UTAH AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

Many States require health-care payers to report certain basic data about paid medical claims to state databases, which are used to improve health-care policy. These state laws apply equally to all public and private plans, including traditional plans, self-funded plans, government programs such as Medicare, and third-party administrators.

The question presented is:

> Whether ERISA preempts a state health-care data collection law as applied to a self-funded ERISA benefit plan, even though the law does not regulate, much less conflict with, the financial disclosures that are required by ERISA in order to assure the financial soundness of a plan.

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INTEREST OF THE *AMICI*[1]

This case presents an important question of preemption under the Employee Retirement Income Security Act of 1974 (ERISA). At stake is whether States can audit the cost and effectiveness of the health care provided within their borders and to their residents by requiring all in-state health-care payers—including self-funded insurance plans[2]—to report medical claims data that such payers collect in the ordinary course of business. At least sixteen States have enacted legislation creating health-care data collection programs of this type.[3]

In the decision below, a divided panel of the Second Circuit held that ERISA preempts these state laws as they apply to self-funded insurance plans. That decision misapprehends the purpose of the laws at issue and rests on an overbroad view of ERISA preemption that this Court long ago abandoned. If

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[1] *Amici* States submit this brief pursuant to Supreme Court Rule 37.4. Counsel of record for all parties received timely notice of *amici* States' intent to file this brief.

[2] A self-funded insurance plan is one in which the employer itself bears the cost and risk of paying for employee health care, instead of contracting that risk to an outside insurance company.

[3] Colo. Rev. Stat. § 25.5-1-204; Conn. Gen. Stat. § 38a-1091; Kan. Stat. Ann. § 65-6804; Me. Rev. Stat. Ann. tit. 22, §§ 8703, 8704; Md. Code Ann., Health-Gen. § 19-133; Mass. Gen. Laws Ann. ch. 12C, § 12; Minn. Stat. Ann. § 62U.04; N.H. Rev. Stat. Ann. § 420-G:11-a; N.Y. Pub. Health Law § 2816; Or. Rev. Stat. § 442.466; R.I. Gen. Laws § 23-17.17-10; Tenn. Code Ann. § 56-2-125; Utah Code Ann. § 26-33a-106.1; Vt. Stat. Ann. tit. 18, § 9410; Va. Code Ann. § 32.1-276.7:1; W. Va. Code § 33-4A-2.

left uncorrected, the decision below will diminish the ability of States to improve the quality and affordability of the health-care services available to their residents.

Amici are the States of New York, Maryland, Massachusetts, New Hampshire, Oregon, and Utah. Each *amicus* State either has created or is developing an all-payer claims database (APCD) to store and analyze medical claims information from all health-care payers within the State. That data describes the health-care services provided within the State and to state residents, and it includes information about the patient's diagnosis, the service provided, the cost of the service, the identity of the provider, and the patient's demographic characteristics (*e.g.*, age and sex). Health-care payers, including the respondent in this case, typically collect this information in the ordinary course of their business. State APCD laws require them to transmit the information they collect to the State, for use in a manner consistent with the privacy protections of the federal Health Insurance Portability and Accountability Act (HIPAA).

In the eleven States with fully functional APCDs, these databases have been a valuable tool for improving the quality and efficiency of health-care services. State authorities have used them to study the frequency and costs of particular types of health-care claims across insurers, regions, or providers, and to develop responsive policies.

New York and Connecticut, which are directly affected by the decision below, are among the five States currently developing and implementing APCDs. New York enacted authorizing legislation in 2011, *see* Ch. 59, pt. H, § 38, 2011 McKinney's N.Y.

Laws 263, 367-68 (*codified as amended at* N.Y Pub. Health Law § 2816), and after several years of pilot studies and other preparatory work, the State is now about a year away from launching an operational database. To date, New York has allocated $10 million for its APCD project. Likewise, Connecticut has been developing its APCD for several years, *see* Conn. Gen. Stat. § 38a-1091, and has received a $6.5 million federal grant to implement its database, which it expects will be operational by the end of 2014, *see* Conn. Health Ins. Exchange, *Policies and Procedures: All-Payer Claims Database,* 1-3 (Dec. 5, 2013); *see also* The Kaiser Family Found., *State Marketplace Profiles: Connecticut* (Sept 27, 2013).

The decision below threatens to disrupt these important health-care policy initiatives. The usefulness of an all-payer claims database comes principally from its comprehensiveness. If a large and distinctive category of payers need not report medical claims data to a state APCD, the database will not accurately reflect the availability and cost of local health-care services, and state authorities cannot rely on it to help them develop health-care policies with a robust evidentiary basis.

Moreover, in the few short months since the Second Circuit's decision, the Sixth Circuit has already rejected its reasoning. The Sixth Circuit criticized the Court below for failing to adhere to the test that this Court has applied in the last two decades—namely, whether the state law actually interferes with the administration of ERISA plans. This circuit split on the fundamental character of ERISA preemption affords an additional reason to grant certiorari.

ARGUMENT

I. The Decision Below Diminishes the Ability of States to Secure Efficient and Effective Health Care for Their Residents.

A. State APCD Laws Promote Efficient and Effective Health Care by Allowing Evidence-Based Policymaking.

Sixteen states, including all of the *amici* states, have enacted APCD laws similar to the Vermont law struck down as preempted in this case. The purpose of these laws is unambiguous: it is to provide the States with data they need to improve the quality of health care while controlling costs. For example, Vermont enacted the law at issue here "to ensure that all residents have access to quality health services and, until health care systems are successful in controlling their costs and resources, to oversee cost containment." Vt. Stat. Ann. tit. 18 § 9401(a) (Pet. App. 91). Connecticut likewise enacted its APCD law to foster "economically sound and medically appropriate health care decisions." Conn. Gen. Stat. § 38a-1091(b)(4)(A). And in New York, APCD legislation was proposed and passed on the understanding that it would "go a long way to improving the quality of care and controlling costs." *See* State Budget Includes Major Health Reforms: Statement by N.Y. State Assembly Health Committee Chair Richard N. Gottfried, March 31, 2011.

Thus, state APCD laws are centrally concerned with "the safe and effective provision of health care services," contrary to the Court below (*see* Pet. App. 18 n.8), and for that reason operate in an area where the presumption against preemption is at is

strongest. The close relationship of state APCD laws to the provision of health-care services is confirmed by their express language calling for the use of APCD data in health-care policymaking. Vermont's law instructs state authorities to use its APCD data for, *inter alia*, "determining the capacity and distribution of existing resources," "identifying health care needs and informing health care policy," "comparing costs between various treatment settings and approaches," and "providing information to consumers and purchasers of health care." Vt. Stat. Ann. tit. 18 § 9410(a) (Pet. App. 92). Similarly, Connecticut's law directs officials to use the State's APCD data "to increase efficiency, enhance outcomes and improve the understanding of health care expenditures in the public and private sectors." Conn. Gen. Stat. § 38a-1091(c)(2). And New York's statute entrusts oversight of its APCD to the Commissioner of Health, who is authorized to use the data to "[e]valuate reform efforts," make "strategic assessments of health care disparities," and "[i]dentify high-performing communities that provide cost-effective care" in ways that could be applied elsewhere. *See* N.Y. State Dep't of Health, *All Payer Database*.

The experiences of the eleven States with fully functional APCDs even more strikingly show how APCDs help to promote efficient and effective health care. New Hampshire has used its APCD to set priorities for improving local access to medical services, by studying the circumstances in which its residents travel to other States to obtain health care. Denise Love et al., *All-Payer Claims Databases: State Initiatives to Improve Health-Care Transparency* 5 (The Commonwealth Fund Issue Brief, Sept. 2010). In Colorado, health-care consumers can use the

State's APCD to compare the prices that different medical providers charge for the same procedure; the cost of a magnetic resonance imaging examination of the knee, for example, ranges from $297 to $1,261 across the twenty largest providers in that State. *See* Ctr. for Improving Value in Health Care, *Imaging Services: Range of Average Imaging Payments to Facilities—2011.* And Utah, in an innovative program, analyzes APCD data about the preventive care its healthiest citizens receive in order to improve the efficacy of preventive care to other citizens. *See* Utah Dep't of Health, *Making* Cents *of Utah's Healthy Population*, Utah Atlas of Health Care, Oct. 2010.

Although New York is still in the process of implementing its APCD, a regional pilot study has already alerted its health authorities that one out of every six hysterectomies performed in the State may be medically unnecessary. *See* N.Y. State Dep't of Health, *New York State All Payer Database Use Cases* 8-9 (Oct. 12, 2011). Based on other states' experiences, New York's health authorities anticipate that its APCD will eventually allow policymakers and health care plans to identify and study, *inter alia*, anomalies in care suggesting a failure to keep pace with evolving medical science, underuse of services resulting in poor health or death, overuse of services resulting in unnecessary and even harmful procedures, misuse of services and treatment errors, and disparities in quality of services across demographic groups. *Id.*

In sum, there can be no dispute that state health-care data collection laws advance the States' regulation of "matters of health and safety." *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund,*

520 U.S. 806, 814 (1997) (citing *Hillsborough County v. Automated Med. Labs., Inc.*, 471 U.S. 707, 715 (1985)). That conclusion finds clear support in the legislative purpose and content of these laws, and in the evidence of how States have put them to use.

B. The Decision Below Undercuts State APCD Initiatives By Excising Key Demographics From State Databases.

In the decision below, the court of appeals held that ERISA preempts the application of state APCD laws to self-funded insurance plans. The direct effect of that ruling will be to create significant and serious gaps in the medical claims data available to state authorities. The vast majority of large companies with more than one-thousand employees insure their workers via self-funded plans (more than eighty-five percent, nationwide), and most private-sector workers with health coverage are insured through such plans (nearly sixty percent, nationwide). *See* Employee Benefit Research Inst., *Self-Insured Health Plans: State Variation and Recent Trends By Firm Size*, Notes, Nov. 2012, at 1. In particular, companies with young, healthy employees are especially likely to opt for self-funding, while traditional commercial insurers are increasingly likely to cover a disproportionately older workforce. *See* Robert Pear, *Employers With Healthy Workers Could Opt Out of Insurance Market, Raising Others' Costs*, N.Y. Times, Feb. 18, 2013, at A9.

If the medical claims data of a large and distinctive subpopulation is omitted from a State's APCD, the APCD will not be able to accurately capture the availability and cost of the health-care services provided within the State and to state

residents. Consequently, state authorities will not be able to rely on the APCD to help them develop health-care policies underpinned by a robust evidentiary basis. The decision below thus threatens to undercut the integrity of state APCDs, and significantly diminish the ability of States with APCD laws to regulate health care through the evidence-based approaches they have elected.

II. The Decision Below Invokes an Overly Broad View of ERISA Preemption That Is in Tension with Recent Precedents of This Court and the Sixth Circuit.

The decision below also threatens harm to state interests through its sweeping approach to ERISA preemption, which is inconsistent with this Court's recent decisions. The Second Circuit essentially held that Vermont's APCD law is preempted by ERISA because both laws contain reporting requirements. The Second Circuit reasoned that ERISA must bar the application of state APCD laws to self-funded plans because APCD laws require reporting of medical claims data and "'reporting' is a core ERISA function shielded from potentially inconsistent and burdensome state regulation." Pet. App. 23; *see also Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983) ("subject matters covered by ERISA" include "reporting, disclosure, fiduciary responsibility, and the like").

But as the dissenting judge observed, that approach "misses the nuance of what 'reporting' means in the context of ERISA, and ignores the case law's focus on whether the *administration of benefits to beneficiaries* is impacted." Pet. App. 32-33 (Straub, J., dissenting in part and concurring in part)). The

state APCD laws at issue here—and the similar APCD laws of the *amici* States—do not conflict with any of ERISA's reporting requirements. ERISA's reporting requirements largely concern disclosure of plan details and finances. *See* 29 U.S.C. §§ 1021-1030. Their purpose is to ensure that plan administrators provide beneficiaries and the United States Department of Labor with information to assess whether the plans are fiscally secure and free from mismanagement or misappropriation of funds. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 15 (1987). In contrast, APCD laws require reporting of medical claims data with the aim of helping States to promote better delivery of health care. There are no points of overlap between State APCD reporting requirements and ERISA's reporting requirements. It thus "make[s] no sense for pre-emption to clear the way for exclusive federal regulation, for there would be nothing to regulate." *Id.* at 16.

ERISA preempts state laws "*insofar* as they relate to any employee benefit plan." 29 U.S.C. § 1144(a) (emphasis added). As this Court has emphasized, that limiting phrase preserves a role for state regulations that do not overlap with or burden compliance with ERISA's requirements, and accordingly do not interfere with ERISA's core purposes. *See N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995); *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985) (overlap); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524-25 (1981) (burden).

The decision below is in grave tension with that principle by holding that even when a state requirement "differs in kind from the 'reporting' that

is required by ERISA," the preemption analysis is unchanged. Pet. App. 24 n.11 (quotation marks omitted). The Second Circuit reasoned that "[a] hodge-podge of state reporting laws, each *more* onerous than ERISA's uniform federal reporting regime, and seeking different and additional data, is exactly the threat that motivates ERISA preemption." Pet. App. 24 n.11 (emphasis in original). But that view misconceives the purposes of ERISA and ERISA preemption. Congress enacted ERISA to "prevent abuses of the special responsibilities borne by those dealing with plans." *Fort Halifax*, 482 U.S. at 15 (quotation marks omitted). ERISA's preemption clause serves that aim by shielding the statute's requirements from potentially inconsistent state regulations that would burden ERISA's objectives by interfering with the obligations it imposes.

The Second Circuit's expansion of ERISA preemption has already precipitated a circuit split. The Sixth Circuit has expressly rejected the decision below, criticizing the Second Circuit for resting its preemption holding on the grounds that both ERISA and Vermont's statute involve "reporting" in a literal sense. *Self-Insurance Inst. of Am., Inc. v. Snyder*, No. 12-2264, --- F.3d ---, 2014 WL 3804355, at *7 (6th Cir. Aug. 4, 2014). The Sixth Circuit, in upholding the law at issue in its case—a one-percent tax on all health-care claims paid for services to Michigan residents that also required plans to submit quarterly tax returns to the state treasury and maintain records for audit purposes, *id.* at *1—took it as a given that States may require employee-benefit plans to submit many kinds of reports, so long as the States do not intrude on ERISA's exclusive regulation of "reports related to the plans' financial stability." *Id.* at *5-*6.

More broadly, the Sixth Circuit recognized that ERISA preemption does not "preclude states from enacting administrative burdens—of any kind—upon plan administrators and sponsors unrelated to the administration of the plans." *Id.* at *5 (citing *Travelers*, 514 U.S. at 655). Rather, the court held, "Congress intended ERISA to preempt state laws providing for additional oversight with regard to the solvency of ERISA plans."[4] *Id.* (emphasis added).

The Sixth Circuit's view is the correct one. Where there are no inconsistent state regulations and no burden on ERISA's objectives, ERISA should not be permitted to "bar state action in fields of traditional state regulation." *Travelers*, 514 U.S. at 655. The Second Circuit's reasoning, by disregarding that principle, would allow ERISA to become a special shield for the very entities it is intended to regulate. Indeed, the "burden" that the Second Circuit found dispositive here was simply the basic financial cost to the self-funded plan of complying with a new rule. Pet. App. 25-27; *see also* Pet. App. 39 (Straub, J., dissenting in part and concurring in part).

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[4] The Sixth Circuit, after rejecting the Second Circuit's ERISA analysis, also distinguished the case before it on the additional grounds that Michigan's law involved the core state function of tax reporting, whereas the data collection law at issue in the Second Circuit's decision appeared not to implicate a core state function. *Self-Insurance Inst. of Am., Inc.*, 2014 WL 3804355, at *7. However, the issue of data collection for APCD purposes was not before the Sixth Circuit, and neither party to its case had occasion to explain why claims-data reporting is in fact inextricably linked to the core state function of improving health care.

As this Court has made clear, however, a state law of "general application" may impose reasonable financial burdens on ERISA plans without being preempted. *De Buono*, 520 U.S. at 815; *see also Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 145 (2d Cir. 1989) ("If ERISA is held to invalidate every State action that may increase the cost of operating employee benefit plans, those plans will be permitted a charmed existence that never was contemplated by Congress." (quotation marks omitted)). In any event, there is considerable irony to the Second Circuit's finding that mandatory participation in a state APCD burdens self-funded plans, because APCD laws are wholly aimed at improving health-care delivery. As New York and other *amici* States have found, health plans can use APCDs to improve their reimbursement models, tailor their contracts to the needs of particular geographic areas, and compare costs across hospitals and providers. See *supra* at 4-7. Any cost associated with reporting APCD data is likely to be counterbalanced by the utility of the data itself.

That the benefits of mandatory participation in a state APCD program will likely exceed any costs is especially clear because APCDs do not require plans to collect any new information. Plans receive claims data from providers and physicians in the ordinary course of their business. To comply with state APCD reporting requirements, the plan need only forward that information to the agency responsible for maintaining the database. As the dissent below noted, respondent's third-party administrator has been providing data to Vermont's APCD for all of its other clients, because the data consists only of "after-the-fact information" that the administrator already

possesses. Pet. App. 39 (Straub, J., dissenting in part and concurring in part). A self-funded plan's preference not to submit its data to a state APCD should not be permitted to undermine the important state interests served by that APCD.

The Second Circuit failed to adhere to this Court's instruction that claims of federal preemption "in fields of traditional state regulation," such as health care, must be addressed "with the starting presumption that Congress does not intend to supplant state law," *Travelers* 514 U.S. at 654-55. Pet. App. 18. To justify its departure from that guiding principle, the Court below advanced a severely narrow view of the presumption's scope.

But this Court's cases do not permit the conclusion that a state health-care law must *directly* dictate "the safe and effective provision of health care services," Pet. App. 18 n.8, in order to merit a presumption against federal preemption. Indeed, the Second Circuit's approach cannot be squared with the far broader understanding of the presumption that this Court adopted in *De Buono*, where it recognized that a gross-receipts tax on all in-patient hospital services, although "a revenue raising measure, rather than a regulation, . . clearly operates in a field that has been traditionally occupied by the States"—namely, "the regulation of matters of health and safety." 520 U.S. at 814 (internal quotation marks omitted). As *De Buono* makes clear, a presumption against federal preemption applies to any state law enacted to improve health care, whether it advances that goal by directly regulating providers, or by indirectly strengthening the health-care system. *See De Buono*, 520 U.S. at 814.

The effect of the Second Circuit's approach to ERISA preemption in this case is to curtail States' authority to regulate not only here but also in many areas of traditional state interest, including health and safety, taxation, and licensing. See Pet. 32-33. Congress did not contemplate that outcome when enacting ERISA.

CONCLUSION

The petition for a writ of certiorari should be granted.

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No. 14-181

In The Supreme Court of the United States

ALFRED GOBEILLE, in his official capacity as chair of the Vermont Green Mountain Care Board,

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

JOINT APPENDIX

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The following opinions and orders have been omitted in printing this Joint Appendix because they appear on the following pages in the appendix to the Petition for a Writ of Certiorari:

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U.S. District Court
District of Vermont (Burlington)
CIVIL DOCKET FOR CASE #: 2:11-cv-00204-wks

Liberty Mutual Insurance Company v. Kimbell
Assigned to: Judge William K. Sessions III
Cause: 29:1001 E.R.I.S.A.: Employee Retirement

Date Filed: 08/12/2011
Jury Demand: None
Nature of Suit: 791 Labor: E.R.I.S.A.
Jurisdiction: Federal Question

Date Filed	#	Docket Text
08/12/2011	1	VERIFIED COMPLAINT for Declaratory Judgment and Other Relief against Stephen W. Kimbell filed by Liberty Mutual Insurance Company. (Attachments: # 1 Exhibit A, # 2 Civil Cover Sheet)(law) (Entered: 08/12/2011)
08/12/2011	2	MOTION for Preliminary Injunction filed by Liberty Mutual Insurance Company (Attachments: # 1 Memorandum in Support)(law) (Entered: 08/12/2011)
08/25/2011	11	MOTION to Withdraw 2 MOTION for Preliminary Injunction filed by Liberty Mutual Insurance Company.(Behm, R.) (Entered: 08/25/2011)
08/25/2011	12	ORDER granting 11 Motion to Withdraw 2 Motion for Preliminary Injunction. Signed by Judge William K. Sessions III on 08/25/11. (This is

		a text only Order.) (eae) (Entered: 08/25/2011)
09/15/2011	15	MOTION to Dismiss filed by Stephen W. Kimbell.(Cassetty, David) (Entered: 09/15/2011)
11/01/2011	22	RESPONSE in Opposition re 15 MOTION to Dismiss filed by Liberty Mutual Insurance Company. (Attachments: # 1 Declaration of Mary Connolly, # 2 Exhibit A, # 3 Exhibit B, # 4 Exhibit C, # 5 Exhibit D)(Behm, R.) (Entered: 11/01/2011)
11/22/2011	25	REPLY in Support of 15 MOTION to Dismiss filed by Stephen W. Kimbell. (Cassetty, David) Text clarified on 11/23/2011 (jlh). (Entered: 11/22/2011)
11/28/2011	26	MOTION for Leave to File *a Sur-Reply in Opposition* as to 15 MOTION to Dismiss filed by Liberty Mutual Insurance Company. (Attachments: # 1 Attachment 1)(Behm, R.) Attachment description clarified on 11/28/2011 (law). (Entered: 11/28/2011)
11/29/2011	28	ORDER granting as unopposed 26 Motion for Leave to File a Sur-Reply in Opposition as to 15 Motion to Dismiss. Signed by Judge William K. Sessions III on 11/29/11. (This is a text only Order.) (eae) (Entered: 11/29/2011)

06/25/2012	35	MOTION for Summary Judgment filed by Liberty Mutual Insurance Company. (Attachments: #1 Memorandum in Support, # 2 Statement of Undisputed Material Facts)(Behm, R.) (Entered: 06/25/2012)
06/25/2012	36	DECLARATION of Mary Connolly re: 35 MOTION for Summary Judgment by Liberty Mutual Insurance Company.. (Behm, R.) (Entered: 06/25/2012)
06/25/2012	37	DECLARATION of John A. Litwinski re: 35 MOTION for Summary Judgment by Liberty Mutual Insurance Company.. (Attachments: # 1 Exhibit A, # 2 Exhibit B, # 3 Exhibit C – part 1, # 4 Exhibit C – part 2, # 5 Exhibit D, # 6 Exhibit E, # 7 Exhibit F, # 8 Exhibit G, # 9 Exhibit H, # 10 Exhibit I, # 11 Exhibit J, # 12 Exhibit K)(Behm, R.) (Entered: 06/25/2012)
08/17/2012	48	RESPONSE in Opposition to 35 MOTION for Summary Judgment filed by Stephen W. Kimbell. (Attachments: # 1 Affidavit of Dian Kahn, # 2 Statement of Disputed Material Facts)(Cassetty, David) (Entered: 08/17/2012)
09/05/2012	49	NOTICE *of Supplemental Authority* by Stephen W. Kimbell (Attachments: # 1 Self-Insurance Institute of America, Inc. v. Snyder, case no. 11-15602, 2012WL3779172)(Cassetty, David)

Attachment description clarified on 9/5/2012 (law). (Entered: 09/05/2012)

09/06/2012 51 REPLY to Response to 35 MOTION for Summary Judgment filed by Liberty Mutual Insurance Company. (Behm, R.) Text clarified on 9/6/2012 (law). (Entered: 09/06/2012)

09/10/2012 52 MOTION for Leave to File *a Response* as to 49 Notice *of Supplemental Authority* filed by Liberty Mutual Insurance Company. (Attachments: # 1 Exhibit A)(Behm, R.) Text clarified on 9/10/2012 (law). (Entered: 09/10/2012)

09/19/2012 56 MINUTE ENTRY for proceedings held before Judge William K. Sessions III: Motion Hearing held on 9/19/2012 re 35 MOTION for Summary Judgment, 15 MOTION to Dismiss. Miller Baker, Esq., Andrew Liazos, Esq. &Jeffrey Behm, Esq. present for pltf; David Cassetty, Esq. &Clifford Peterson, Esq. present for dft. Court makes inquiries. Statements by counsel. Motions Taken Under Advisement: 35 MOTION for Summary Judgment, 15 MOTION to Dismiss. (Court Reporter: Nichols Pierce) (jam) (Entered: 09/19/2012)

10/02/2012 57 TRANSCRIPT of Motion to Dismiss and Motion for Summary Judgment Hearing held on 9/19/2012 before Judge Sessions. Court Reporter/

Transcriber Anne Nichols Pierce, Telephone number 802-860-2227. Transcript may be viewed at the court public terminal or purchased through the Court Reporter/ Transcriber before the deadline for Release of Transcript Restriction. After that date it may be obtained through PACER Redaction Request due 10/25/2012. Redacted Transcript Deadline set for 11/2/2012. Release of Transcript Restriction set for 12/31/2012. (jam) (Entered: 10/02/2012)

10/05/2012 58 POST-HEARING MEMORANDUM re: 35 MOTION for Summary Judgment by Liberty Mutual Insurance Company. (Attachments: # 1 Declaration of John A. Litwinski, # 3 Exhibit A, # 4 Exhibit B, # 5 Exhibit C, # 2 Declaration of Mary Connolly)(Behm, R.) (Attachment 1 broken out on 10/7/2012) (law). (Entered: 10/05/2012)

10/07/2012 59 NOTICE OF DOCKET ENTRY CORRECTION re: 58 Post-Hearing Memorandum filed by Liberty Mutual Insurance Company. The Declaration of John A. Litwinski document image contained that of Exhibits A, B and C. The images have been broken apart and replaced on the docket. The corrected images are also attached to this entry. (Attachments:

		# 1 Exhibit A, # 2 Exhibit B, # 3 Exhibit C) (law) (Entered: 10/07/2012)
10/10/2012	60	RESPONSE re 58 Post-Hearing Memorandum re: 35 MOTION for Summary Judgment by Stephen W. Kimbell. (Cassetty, David) Link added on 10/10/2012 (jlh). (Entered: 10/10/2012)
11/09/2012	61	OPINION AND ORDER denying 35 Motion for Summary Judgment; granting 52 Motion for Leave to Respond to dft's Notice of Supplemental Authority; granting in part and denying in part 15 Motion to Dismiss, granted with respect to ERISA preemption and denied with respect to standing. Signed by Judge William K. Sessions III on 11/9/2012. (jam) (Entered: 11/09/2012)
11/12/2012	62	JUDGMENT granting 15 motion to dismiss with respect to preemption. Signed by Deputy Clerk on 11/12/2012. (Attachments: # 1 Notice to Litigants (appeal period expires (12/13/2012))(law) (Entered: 11/12/2012)
12/10/2012	63	NOTICE OF APPEAL as to 61 Opinion and Order; 62 Judgment by Liberty Mutual Insurance Company. Filing fee $ 455. Paid R# 4682008141. (gmg) (Entered: 12/10/2012)

12/19/2012	64	TRANSMITTED Index on Appeal Circuit No. 12-4881 re: 63 Notice of Appeal. (gmg) (Entered: 12/19/2012)
05/23/2014	67	MANDATE of USCA Circuit No. 12-4881 as to 63 Notice of Appeal filed by Liberty Mutual Insurance Company. It is ORDERED that the 62 judgment of the district court is REMANDED with instructions to enter judgment for Liberty Mutual in accordance with the opinion of this court. (Attachments: # 1 Opinion)(gmg) (Entered: 05/23/2014)

General Docket
Court of Appeals, Second Circuit

Court of Appeals Docket #: 12-4881 **Docketed:** 12/13/2012
Termed: 02/04/2014
Nature of Suit: 3791 LABOR LAWS-Retirement Act 1974
Liberty Mutual Insurance Compa v. Kimbell
Appeal From: DISTRICT OF VERMONT (BURLINGTON)
Fee Status: Paid

12/13/2012	1	NOTICE OF CIVIL APPEAL, with district court docket, on behalf of Appellant Liberty Mutual Insurance Company, FILED. [794017] [12-4881] [Entered: 12/13/2012 09:08 AM]
12/27/2012	34	ELECTRONIC INDEX, in lieu of record, FILED.[804980] [12-4881] [Entered: 01/02/2013 11:09 AM]
03/29/2013	50	BRIEF & SPECIAL APPENDIX, on behalf of Appellant Liberty Mutual Insurance Company, FILED. Service date 03/29/2013 by CM/ECF. [892448] [12-4881] [Entered: 03/29/2013 02:47 PM]
03/29/2013	51	JOINT APPENDIX, volume 1 of 2, (pp. 1-286), on behalf of Appellant Liberty Mutual Insurance Company, FILED. Service date 03/29/2013 by CM/ECF.[892486] [12-4881] [Entered: 03/29/2013 03:04 PM]

03/29/2013	52	JOINT APPENDIX, volume 2 of 2, (pp. 287-382), on behalf of Appellant Liberty Mutual Insurance Company, FILED. Service date 03/29/2013 by CM/ECF.[892491] [12-4881] [Entered: 03/29/2013 03:07 PM]
04/09/2013	64	AMICUS BRIEF, on behalf of Amicus Curiae Chamber of Commerce of the United States of America, FILED. Service date 04/09/2013 by CM/ECF. [901090] [12-4881] – [Edited 04/09/2013 by JW] [Entered: 04/09/2013 11:24 AM]
06/19/2013	71	Stephen Kimbell, replaced by Susan L. Donegan, SUBSTITUTED.[973819] [12-4881] [Entered: 06/24/2013 04:35 PM]
06/24/2013	72	AMENDED CAPTION PAGE, removing Stephen Kimbell and substituting in Susan Donegan and her title, SENT.[973826] [12-4881] [Entered: 06/24/2013 04:36 PM]
06/27/2013	73	BRIEF, on behalf of Appellee Susan L. Donegan, FILED. Service date 06/27/2013 by CM/ECF. [977273] [12-4881] [Entered: 06/27/2013 02:28 PM]
07/10/2013	81	AMICUS BRIEF, on behalf of Amicus Curiae Seth D. Harris, FILED. Service date 07/03/2013 by CM/ECF. [985743] [12-4881] – [Edited 07/10/2013 by JW] [Entered: 07/10/2013 12:07 PM]

07/17/2013	88	REPLY BRIEF, on behalf of Appellant Liberty Mutual Insurance Company, FILED. Service date 07/17/2013 by CM/ECF. [993230] [12-4881] [Entered: 07/17/2013 05:48 PM]
11/18/2013	110	CASE, before ALK, DJ, CJS, C.JJ., HEARD.[1094990] [12-4881] [Entered: 11/18/2013 12:13 PM]
02/04/2014	118	OPINION, the district court judgment is reversed and remanded with instructions to enter judgment for Liberty Mutual, by ALK, DJ, CJS, FILED.[1148788] [12-4881] [Entered: 02/04/2014 09:19 AM]
02/04/2014	119	OPINION, Concurring & Dissenting, by Judge Straub, FILED.[1148794] [12-4881] [Entered: 02/04/2014 09:22 AM]
02/04/2014	121	CERTIFIED OPINION, dated 02/04/2014, to DISTRICT OF VERMONT (BURLINGTON), ISSUED. [1148804] [12-4881] [Entered: 02/04/2014 09:26 AM]
02/04/2014	125	JUDGMENT, FILED.[1149244] [12-4881] [Entered: 02/04/2014 12:39 PM]
02/18/2014	126	PETITION FOR REHEARING/ REHEARING EN BANC, on behalf of Appellee Susan L. Donegan, FILED. Service date 02/18/2014 by US mail, CM/ECF.[1158736] [12-4881] [Entered: 02/18/2014 03:55 PM]

05/16/2014 130 ORDER, petition for rehearing en banc denied, FILED.[1226687] [12-4881] [Entered: 05/16/2014 01:47 PM]

05/23/2014 131 JUDGMENT MANDATE, ISSUED. [1232584] [12-4881] [Entered: 05/23/2014 02:44 PM]

08/15/2014 132 U.S. SUPREME COURT NOTICE of writ of certiorari filing, dated 08/15/2014, U.S. Supreme Court docket # 14-181, RECEIVED. [1298748] [12-4881] [Entered: 08/19/2014 01:26 PM]

06/29/2015 136 U.S. SUPREME COURT NOTICE, dated 06/29/2015, U.S. Supreme Court docket # 14-181, stating the petition for writ of certiorari is granted, RECEIVED.[1543469] [12-4881] [Entered: 06/30/2015 11:42 AM]

UNITED STATES DISTRICT COURT
DISTRICT OF VERMONT

Liberty Mutual Insurance Company Plaintiff, v. Stephen W. Kimbell, in his capacity as the Vermont Commissioner of Banking, Insurance, Securities and Health Care Administration, Defendant.	)	2:11-cv-204

VERIFIED COMPLAINT FOR DECLARATORY JUDGMENT AND OTHER RELIEF

Plaintiff Liberty Mutual Insurance Company ("Liberty Mutual"), through its undersigned attorneys, for its verified complaint against defendant Stephen W. Kimbell ("Defendant") in his capacity as the Vermont Commissioner of Banking, Insurance, Securities and Health Care Administration ("BISHCA"), states as follows:

JURISDICTION AND VENUE

1. This is an action pursuant to the Declaratory Judgment Act, 28 U.S.C. § 2201, *et seq.* and the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* This case involves

an actual controversy between the parties as to whether ERISA preempts a state statute and regulation requiring the disclosure to BISHCA of confidential health care information and records of medical treatment provided to private individuals in Vermont.

2. This Court has subject matter jurisdiction under both ERISA Section 502(e)(1), which provides the Court with exclusive jurisdiction to hear suits under Section 502(a)(3), and 28 U.S.C. § 1331.

3. Venue in this Court is proper under Section 502(e)(2) of ERISA because this is the District where the threatened violation of ERISA will take place and because the Defendant resides or may be found in this District.

PARTIES

4. Plaintiff Liberty Mutual is an insurance company organized under the laws of the Commonwealth of Massachusetts. Liberty Mutual is a wholly owned subsidiary of Liberty Mutual Group Inc. Liberty Mutual's principal offices are located at 175 Berkeley Street, Boston, Massachusetts 02116. Liberty Mutual has employees and offices in Vermont and conducts business in Vermont.

5. Defendant Stephen W. Kimbell is Commissioner of BISHCA for the State of Vermont, and is named as Defendant in that capacity. Pursuant to Vermont statutory authority, BISHCA has promulgated Regulation H-2008-01 ("Regulation"), which

generally requires that private health care data and records of individuals' medical treatment be provided to BISHCA. The Regulation is intended to implement the creation of a "unified health care data base" pursuant to 18 V.S.A. § 9410. The Regulation states that it was "issued pursuant to the authority vested in the Commissioner of" BISHCA.

BACKGROUND AND FACTS

A. Liberty Mutual's ERISA-Governed Employee Welfare Benefit Plan and Its Third Party Administrator

6. Approximately 54 years ago, Liberty Mutual established the Liberty Mutual Medical Plan (the "Plan") for the benefit of its employees. The Plan provides a broad range of medical care benefits to Liberty Mutual's employees and their beneficiaries. As of June 30, 2011, the Plan provides medical benefits to 84,711 persons throughout the United States, including 32,933 employees of Liberty Mutual Group Inc. and its subsidiaries, as well as employees' families and company retirees. Of these people, 137 are in Vermont, including all company employees in Vermont and their families. Liberty Mutual does not offer the right to participate in the Plan to a Vermont resident unless such individual is an employee of Liberty Mutual Group Inc., or one of its participating subsidiaries, a qualifying family member of such an employee, or an eligible company retiree.

7. The Plan is an employee welfare benefit plan governed by ERISA. *See* ERISA Section 3(1), codified at 29 U.S.C. § 1002(1). Liberty Mutual was at all times relevant hereto a "named fiduciary" and "plan administrator" of the Plan within the meaning of Section 3 of ERISA, 29 U.S.C. § 1002. Liberty Mutual Group Inc. is the "Plan Sponsor" within the meaning of Section 3 of ERISA, 29 U.S.C. § 1002.

8. The Plan provides medical benefits that are self-insured by Liberty Mutual Group Inc., meaning that Liberty Mutual Group Inc. pays all benefits provided under the Plan from its own general assets. Blue Cross Blue Shield of Massachusetts, Inc. ("BCBSMA" or the "TPA") is the Plan's third party administrator, and it administers the medical claims and associated confidential medical records of Plan participants and beneficiaries. BCBSMA is also in possession of, and on an ongoing basis continues to receive, confidential and private medical data and records involving Plan participants and beneficiaries.

B. The Pertinent ERISA Provisions

9. ERISA is a comprehensive federal statute that regulates private employee benefit plans in order to provide protection to plan participants and beneficiaries. *See Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 209 (2002); http://www.dol.gov/dol/topic/health-plans/erisa.htm (last visited August 11, 2011). One of the primary purposes of ERISA is to provide for the "uniform national treatment" of

employee benefit plans. *Arnold v. Lucks*, 392 F.3d 512, 519 (2d Cir. 2004) (citing *Yates Profit Sharing Plan v. Hendon*, 124 S. Ct. 1330, 1331 (2004)).

10. "ERISA expressly preempts 'any and all State laws insofar as they may now or hereafter relate to any employee benefit plan' covered by the statute." *Geller v. County Line Auto Sales, Inc.*, 86 F.3d 18, 22 (2d Cir. 1996) (citations omitted). "The express preemption provisions of ERISA are deliberately expansive. . . . [and] are among the broadest that can be found in the law." *Id.*

11. Section 404 of ERISA governs how fiduciaries of ERISA-governed plans are to behave. *See generally* ERISA § 504, codified at 29 U.S.C. § 1104. Section 404(a)(1)(A) of ERISA provides that a plan fiduciary, like Liberty Mutual, "shall discharge his duties with respect to a plan *solely in the interest of the participants and beneficiaries* and . . . *for the exclusive purpose* of (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan." ERISA § 404(a)(1)(A), codified as 29 U.S.C. § 1104(a)(1)(A) (emphasis added). Accordingly, ERISA forbids Liberty Mutual, a Plan fiduciary, from using the Plan for any purpose other than to provide benefits to Plan participants and beneficiaries.

12. In addition, ERISA provides "detailed reporting and disclosure requirements." *Massachusetts v. Morash*, 490 U.S. 107, 118 (1999); *see* 29 U.S.C. §§ 1023-1030. Part 1 of Subtitle B of ERISA

sets forth the reporting and disclosure duties of an administrator of a large employee welfare benefit plan such as the Plan. These requirements include publishing an annual report that is filed with the Secretary of Labor. *See* Section 103 of ERISA The annual report sets forth identifying information regarding the plan, the number of participants, the plan's funding arrangement and the plan's benefit arrangement. The annual report does not require any disclosure of the confidential, individualized health care and medical claims information sought by BISHCA. *See* ERISA Section 106, codified at 29 U.S.C. § 1026. Section 502(c)(2) of ERISA and the regulations thereunder set forth the penalties for failure to comply with ERISA's annual reporting requirements.

13. ERISA makes clear that the United States Department of Labor is the entity Congress contemplated and authorized to collect and analyze data regarding ERISA health plans. Section 513 of ERISA expressly gives the Secretary of Labor "authori[ty] to undertake research and surveys and in connection therewith to collect, compile, analyze and publish data, information, and statistics relating to . . . welfare plans" such as the Plan. 29 U.S.C. § 1143(a). ERISA does not provide the States with authority to collect data from ERISA plans, but rather vests that authority in the Department of Labor.

14. Despite its considerable breadth, ERISA preemption does not extend to state laws that regulate only insurance, banking, or securities. *See* ERISA

§ 514(b)(2)(A), codified at 29 U.S.C. § 1144(b)(2)(A). This exception to the general rule of ERISA preemption is known as the "Savings Clause." Under the Savings Clause, states are generally permitted to enact laws regulating only insurance. *See id.*

15. The "Deemer Clause" was also included in Section 514 of ERISA to ensure that the Savings Clause was not used as an end-run around ERISA's sweeping preemption provision. *See* ERISA § 514(b)(2)(B), codified at 29 U.S.C. § 1144(b)(2)(B). The Deemer Clause provides that a self-funded plan shall not "be deemed to be an insurance company . . . or to be engaged in the business of insurance . . . for purposes of any state law purporting to regulate" insurance businesses. *Id.* The Deemer Clause makes clear that a state law will not avoid ERISA preemption by merely deeming an employee benefit plan to be an insurer.

16. Nothing in ERISA permits a State to deem a self-insured employee welfare benefit plan or those providing administrative services to such a plan to be an insurance company so that it can require reporting of confidential, personal medical information to create its own proprietary health care database.

C. BISHCA and the Regulation

17. BISHCA is a Vermont state agency which, according to its website, "provid[es] a single point of access for consumer complaint resolution, enforcement authority, and legislative contact on issues

affecting financial and health care services in Vermont." http://www.bishca.state.vt.us/ (last visited Aug. 7, 2011). The Division of Health Care Administration, one of BISHCA's divisions, "regulates and monitors key sectors of Vermont's health care system to ensure that all Vermonters have access to health care that is affordable and meets accepted standards for quality." http://www.bishca.state.vt.us/health-care/health-care-administration (last visited Aug. 9, 2011). The Defendant is the Commissioner of BISHCA.

18. The state of Vermont has enacted 18 V.S.A. § 9410 (the "Statute") in its effort to regulate heath care administration. The Statute calls for BISHCA to create a "unified health care database," so that the Commissioner of BISHCA can carry out certain duties. *See* 18 V.S.A. § 9410(a)(1). These duties include: 1) determining the capacity and distribution of existing resources; 2) identifying health care needs and informing health care policy; 3) evaluating the effectiveness of intervention programs on improving patient outcomes; 4) comparing costs between various treatment settings and approaches; 5) providing information to consumers and purchasers of health care; and 6) improving the quality and affordability of patient health care and health care coverage. *See* 18 V.S.A. § 9410(a)(1)(A)-(F). These goals have nothing to do with regulating insurance but are, instead, directly aligned with the stated mission of BISHCA's Division of Health Care Administration. BISHCA is also granted enforcement responsibilities under the Statute.

19. Pursuant to the Statute, BISHCA promulgated Regulation H-2008-01 (the "Regulation") to implement the creation of a "unified health care data base." The Regulation states that "[t]he purpose of this rule is to set forth the requirements for the *submission of health care claims data, member eligibility data, and other information relating to health care* provided to Vermont residents or by Vermont health care providers and facilities by health insurers, managed care organizations, *third party administrators*, pharmacy benefit managers and others to [BISHCA] . . . and conditions for the use and dissemination of such claims data . . . consistent with the purposes of 18 V.S.A. § 9410." *See* Regulation Section 1 (emphasis added).

20. In furtherance of this purpose, the Regulation requires "Health Insurers" to "regularly submit *medical claims data, pharmacy claims data, member eligibility data, provider data, and other information relating to health care* provided to Vermont residents and health care provided by Vermont health care providers and facilities to both Vermont residents and non-residents in specified electronic format to [BISHCA]." *See* Regulation Section 4(A) (emphasis added).

21. The Regulation broadly defines "Health Insurer" to include any "third party administrator . . . and any entity conducting administrative services for business or possessing claims data, eligibility data, provider files, and other information relating to health care provided to Vermont residents or by

Vermont health care providers and facilities. The term may also include . . . any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities." *See* Regulation § 3(X). By its terms, the definition includes plan administrators, like Liberty Mutual, and third party administrators, like BCBSMA.

22. Accordingly, the Regulation requires Liberty Mutual and BCBSMA to annually report the Plan's private health care data and records of individuals' medical treatment to BISHCA.

D. The Issuance of the BISHCA Subpoena

23. BISHCA has repeatedly attempted to apply the Statute and Regulation to Liberty Mutual's ERISA-governed Plan. BISHCA has recently made several demands that Liberty Mutual and BCBSMA report the Plan's medical claims data. The information sought includes Plan participants' and beneficiaries' name, gender, date of birth, city zip code, social security number, diagnosis and procedure code, type of bill paid, amount charged, the co-payment or coinsurance amount, and drug code, among other information. *See* Regulation, at Appendix C-1.

24. In late May 2011, BCBSMA informed Liberty Mutual that BISHCA was being "very aggressive" in its efforts to enforce the claims data reporting Regulation and was pressuring BCBSMA to report the claims data for Liberty' Mutual's Plan.

25. Both Liberty Mutual and BCBSMA have made numerous attempts to persuade BISHCA to abandon its efforts to apply the Regulation to the Plan. On June 6, 2011, Mary Connolly, the Vice President of Benefits at Liberty Mutual, and Liberty Mutual's Counsel Nancy L. Keating, spoke with Clifford Peterson, General Counsel for the Health Care Division of BISHCA, regarding the Vermont reporting rules and the issue of ERISA preemption. During that discussion, Mr. Peterson indicated that BISHCA would likely take enforcement action against BCBSMA if it failed to report the individual medical records and data of Plan participants and beneficiaries in the precise manner demanded by BISHCA. Liberty Mutual requested that BISHCA reconsider its insistence that the TPA report confidential health care information and participant medical records.

26. Subsequently, Jack Myers of BCBSMA communicated to Ms. Connolly that BISCHA "was about to take imminent action against" BCBSMA if it failed to submit the specific information, records and data demanded by BISCHA regarding Plan participants and beneficiaries.

27. On July 29, 2011, Ms. Connolly and Ms. Keating again spoke to BISHCA General Counsel Clifford Peterson and informed him that Liberty Mutual would continue to instruct BCBSMA not to report the claims data to BISHCA as it was inconsistent with the requirements of ERISA, and BISHCA had no right to compel a self-insured medical plan to

disclose confidential health care information so BISHCA could create a health care database, because the Regulation was preempted by ERISA. Mr. Peterson responded that ERISA did not preempt the Vermont reporting rules.

28. Subsequently, on August 5, 2011, the Defendant served a subpoena on BCBSMA and Blue Cross Blue Shield of Massachusetts HMO Blue, Inc.[1] (the "Subpoena"). *See* Exhibit A.

29. The Subpoena demands that the TPA produce "Eligibility files for the following months of incurred service for 2011: April, May, June"; "Medical claim files for the following months of incurred service for 2011: January, April, May, June"; and "Pharmacy claim files for the following months of incurred service for 2011: April, May, June." The data demanded in the Subpoena includes personal identifying information regarding individual Plan participants' and beneficiaries' medical treatment, including Plan member name, gender, date of birth, city zip code, social security number, diagnosis and procedure code, type of bill paid, amount charged, co-payment or coinsurance amount, and drug code, among other items of information.

30. The Subpoena states that "*the files which precede the June filing period are overdue to the*

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[1] Blue Cross Blue Shield of Massachusetts HMO Blue, Inc. does not provide services to the Plan, nor has the Plan provided medical records or data to that entity.

Department, and the June filings are due by July 31, 2011." (emphasis added).

31. The Subpoena further states that "[p]ursuant to 8 V.S.A. § 13(b), a person who fails or refuses to produce papers or records . . . ***may be assessed a penalty by the Commissioner of not more than $2,000.00 for each day*** of noncompliance and proceeded against as provided in the Administrative Procedure act, and that person's ***authority to do business may be suspended*** for not more than six months." (emphasis added).

E. <u>The Controversy Between the Parties</u>

32. Liberty Mutual, as the Plan administrator, has repeatedly resisted BISHCA's attempt to require the reporting or other disclosure of the confidential information, records, and data of Plan participants and beneficiaries, for three primary reasons.

33. First, the Statute and Regulation are preempted by ERISA. Specifically, the Statute and Regulation impose a new reporting regime on self-funded medical plans that requires reporting and disclosure different in kind and in scope from what is imposed under ERISA. As such, the Statute and Regulation are an attempt to intrude upon the uniform and exclusive regulation of employee benefit plans that Congress provided under ERISA. BISHCA has attempted to avoid ERISA's preemptive effect by defining "Health Insurers" to include plan administrators and third party administrators. However, this

is nothing more than a legal fiction designed to allow BISHCA to improperly seek the confidential health care information, private medical records, and data of the Plan's participants and beneficiaries. Significantly, ERISA's Deemer Clause expressly rejects states' attempts to classify employee benefit plans as insurance companies in order to regulate them. BISHCA's attempt to treat Liberty Mutual and BCBSMA as "health insurers" is further belied by the fact that no Vermont resident without ties to Liberty Mutual Group Inc. and its subsidiaries can purchase insurance under the Plan.

34. Second, providing the Plan's claims data to BISHCA under the Statute and Regulation could constitute a violation of Liberty Mutual's ERISA fiduciary duties. The duties outlined in Section 404 of ERISA compel Liberty Mutual to safeguard against the type of detailed and intrusive reporting regime being imposed by BISHCA, particularly because BISHCA may release claims data to various third parties who request such data. *See* Regulation Section 9. Quite simply, the Plan may not be administered at the expense of the Plan and its participants in order to develop a health care database so that the State of Vermont can best determine how health care should be provided to residents.

35. Third, the Plan owns the claims data that BISHCA seeks, and Liberty Mutual Group Inc. and its subsidiaries, as a national employer, has designed the Plan to meet its own competitive needs in the marketplace. Accordingly, BISHCA is not entitled to

information related to the Plan design, including which claims the Plan does and does not cover or what a member's required coinsurance or copayments may be under the Plan, nor is it entitled to information relating to a participant's confidential medical claims information. BISHCA is similarly not entitled to compel the Plan's service providers (like BCBSMA) to report such information, irrespective of whether that individual is or is not a Vermont resident, since the service providers have no right to release the data to BISHCA without Liberty Mutual's consent.

COUNT I
ERISA Section 502(a)(3)

36. Plaintiff re-alleges and incorporates by reference all preceding allegations in this Complaint as though fully set forth in this Count I.

37. Section 502(a)(3) of ERISA provides that "[a] civil action may be brought . . . by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan."

38. There exists an actual controversy between Liberty Mutual and Defendant, which controversy can be resolved by a judgment of this Court.

39. Defendant subpoenaed the TPA demanding it turn over confidential health care information and

private medical records and data of Liberty Mutual's Plan participants and beneficiaries, and threatening the TPA with substantial fines and loss of its ability to do business in Vermont if it does not comply with the subpoena. The TPA has indicated that absent preliminary injunctive relief from this Court, the TPA will be forced to, and will, comply with the Subpoena and turn over the medical records and data being demanded.

40. Liberty Mutual, as Plan administrator and named fiduciary, therefore sues under Section 502(a)(3) of ERISA seeking a declaratory judgment and to enjoin Defendant's attempt to force the TPA to produce the subpoenaed information because Defendant's actions, and the Regulation and 18 V.S.A. § 9410, each violate and are preempted by ERISA.

41. Plan participants and beneficiaries who are Vermont residents, as well as the Plan and its fiduciaries, will suffer irreparable harm if enforcement of the Subpoena is not preliminarily and permanently enjoined.

WHEREFORE, Liberty Mutual respectfully requests that this Court:

A. Declare that BISHCA's Regulation H-2008-01 and the Vermont health care database statute set forth in 18 V.S.A. § 9410 are preempted by ERISA to the extent they require the reporting, production, or disclosure of any confidential health care information or medical records or data relating to the Plan or its participants and beneficiaries;

B. Preliminarily and permanently enjoin the Defendant from attempting to obtain, from the TPA or any other source, any medical records or data relating to the Plan or its participants and beneficiaries;

C. Award Liberty Mutual its reasonable attorney's fees and costs incurred in this action pursuant to ERISA Section 502(g); and

D. Grant such further equitable relief as may be deemed appropriate.

Dated: August 12th, 2011

Respectfully submitted,

/s/ R. Jeffrey Behm

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VERIFICATION

I, Mary Connolly, have reviewed the allegations made in this Verified Complaint and swear and affirm under penalties of perjury of the laws of the United States of America that they are true and correct to the best of my knowledge and belief.

/s/ Mary Connolly
Mary Connolly
Vice President & Manager of Benefits
Liberty Mutual Insurance Company

Subscribed and sworn to
before me this 12 day of
August, 2011

/s/ Jeanne Morse
Notary Public

[SEAL]

STATE OF VERMONT
DEPARTMENT OF BANKING, INSURANCE, SECURITIES AND HEALTH CARE ADMINISTRATION

TO: Blue Shield of Massachusetts HMO Blue, Inc. AND Blue Cross and Blue Shield of Massachusetts, Inc.	))))	Docket No. 11-035-H

SUBPOENA

Pursuant to the authority contained in 8 V.S.A. §13, YOU ARE HEREBY DIRECTED TO PRODUCE to *Onpoint Health Data*, duly-appointed contractor of the Department of Banking, Insurance, Securities and Health Care Administration, located at 16 Association Drive, Manchester, Maine, 04351, THE INFORMATION, DATA, AND DOCUMENTS SPECIFIED IN THE ATTACHED EXHIBIT "A" on or before *August 10, 2011* and pursuant to the instructions in Exhibit "A." The data should be submitted in the same manner as previous submissions.

The terms "information, data, and documents" include, but are not limited to, all records and other tangible forms of expression, drafts or finished versions, originals, copies of annotated copies, however produced or stored (manually, mechanically, electronically or otherwise), including but not limited to books, papers, files, notes, correspondence, memoranda, ledger sheets, reports, telegrams, telexes, facsimiles, telephone logs, contracts, agreements, calendars or date books, phone logs, bank statements, worksheets, computer

files including electronic mail, software disk packs and other electronic media and the documents generated therefrom, microfilm, microfiche, and storage devices.

Pursuant to 8 V.S.A. § 13(b), a person who fails or refuses to produce papers or records for examination before the Commissioner, upon properly being ordered to do so, may be assessed an administrative penalty by the Commissioner of not more than $2,000.00 for each day of noncompliance and proceeded against as provided in the Administrative Procedure Act, and that person's authority to do business may be suspended for not more than six months.

Dated at Montpelier, Vermont this 2nd day of August, 2011.

By: /s/ S. W. Kimball
STEPHEN W. KIMBALL,
COMMISSIONER
Vermont Department
of Banking, Insurance,
Securities and Health
Care Administration

Instructions

The following files for Vermont enrollees ("the files") are due to the Vermont Department of Banking, Insurance, Securities and Health Care Administration ("the Department") to meet ongoing reporting requirements of the State's Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) as specified in State Reg. H-2008-01. The files which precede the June filing period are overdue to the Department, and the June filings are due by July 31, 2011 and must be electronically filed with Onpoint Health Data, the State of Vermont's designated contractor.

All files must meet the same filing requirements and be electronically filed in the same manner as the historic production files that have already been submitted to Onpoint Health Data by Blue Cross Blue Shield of Massachusetts, Inc. and Blue Cross Blue Shield of Massachusetts HMO Blue, Inc. for preceding filing periods.

Following production of these files, Blue Cross Blue Shield of Massachusetts, Inc. and Blue Cross Blue Shield of Massachusetts HMO Blue, Inc. are to resume timely submissions of monthly production files.

Data To Be Produced

The files are:

1. Blue Cross Blue Shield of Massachusetts, Inc.

    - Eligibility files for the following months of incurred services for 2011: April, May, June
    - Medical claims files for the following months of incurred services for 2011: January, April, May, June
    - Pharmacy claims files for the following months of incurred services for 2011: April, May, June

2. Blue Cross Blue Shield of Massachusetts HMO Blue, Inc.

    - Eligibility files for the following months of incurred services for 2011: April, May, June
    - Medical claims files for the following months of incurred services for 2011: January, March, April, May, June
    - Pharmacy claims files for the following months of incurred services for 2011: April, May, June

LIBERTY MUTUAL MEDICAL PLAN

Amended and Restated as of January 1, 2001

Liberty Mutual Insurance Company

LIBERTY MUTUAL MEDICAL PLAN

Table of Contents

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[1] LIBERTY MUTUAL MEDICAL PLAN

ARTICLE I. PREAMBLE

Section 1.1 The Plan.

Liberty Mutual Insurance Company (the "Company") established the Liberty Mutual Medical Plan (the "Plan") effective July 1, 1957. The Plan is hereby amended and restated as of January 1, 2001.

Section 1.2 Purpose and Intent.

The purpose of the Plan is to provide to Participants medical benefits.

The Plan is intended to meet all applicable requirements of the Internal Revenue Code ("Code") and the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), as well as rulings and regulations issued or promulgated thereunder. Nothing in the Plan shall be construed as requiring compliance with Code or ERISA provisions that do not otherwise apply.

Section 1.3 Definitions.

The following terms, where capitalized, shall have the meanings set forth below unless otherwise specified herein:

(a) "Code" means the Internal Revenue Code of 1986, as amended.

(b) "Company" means Liberty Mutual Insurance Company, a mutual insurance company organized under the laws of Massachusetts. In the event of the reorganization, merger or similar transaction affecting the Company, any successor entity may adopt the Plan for the benefit of employees of such successor, in which event, the Plan shall continue without any gap or lapse in coverage.

(c) "Dependent" means (a) an Employee's spouse; and (b) an Employee's unmarried child (including any stepchild, foster child,

legally adopted child or a child for whom a court order of custody or guardianship has been obtained) under age 19. If an unmarried child age 19 or over is a full-time student in a school, college or university, he is a dependent until he reaches age 25. "Dependent" does not include a person who is covered under this Plan as an Employee or a legally divorced spouse (except divorced spouses of Massachusetts employees covered pursuant to Section 110 I of Chapter 175 of the Massachusetts General Laws, prior to 1/1/91). Coverage for a dependent child who reaches age 19 will be continued under this Plan if the dependent child is unable to earn his own living because of a physical handicap, mental illness or developmental disability.

[2] (d) "Effective Date" of the Plan as amended and restated is January 1, 2001.

(e) "Employee" means any individual employed on the U.S. payroll by the Company, or by subsidiaries of the Company that participate in the Plan, on a regular full time basis, or regular part-time basis (if scheduled and regularly working 20 hours or more per week). Individuals classified as independent contractors or leased employees are not eligible for coverage, even if they are later reclassified as common law employees for tax purposes.

(f) "Employer" means the Company, and subsidiaries of the Company that participate in the Plan. The Company shall have the right to

terminate any Employer's adoption of the Plan at any time. If an Employer merges or is otherwise consolidated with any affiliate, the successor shall, as to the group of Employees covered by the Plan immediately before such merger or consolidation, be the Employer as defined hereunder, unless the Company specifies to the contrary. In case of any other merger or consolidation, the successor shall not be the Employer except to the extent that it acts to adopt the Plan. Each Employer is identified in Appendix A. The Company shall amend Appendix A as needed, to reflect an Employer's adoption of the Plan or withdrawal from the Plan, without any need to otherwise amend the Plan.

(g) "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

(h) "Former Employee" means any person formerly employed as an Employee.

(i) "Participant" means an Employee, Former Employee, and Dependents who meet the requirements for eligibility as set forth in Article II and who properly enroll in the Plan.

(j) "Participant Contribution" means the pre-tax or after-tax contribution required to be paid by a Participant, if any, as determined under the SPD, as may be amended from time to time, and which is attached hereto in Appendix B. The term "Participant Contribution" includes contributions used to purchase insurance contracts or policies.

(k) "Plan" means the Liberty Mutual Medical Plan, which consists of this document, the SPD incorporated hereunder by reference as may be amended from time to time, and any document describing the HMO options which from time to time may be offered to Participants and which are attached hereto in Appendix B.

(l) "Plan Administrator" means the Company.

(m) "Plan Year" means each twelve (12) consecutive month period commencing [3] January 1 and ending on December 31.

(n) "SPD" means any summary plan description, as may be amended from time to time, summary of material modifications, or other employee communication, which describes the benefits under the Plan, and which has been included by the Employer as part of this Plan under Appendix B.

Section 1.4 Interpretation.

The Plan shall consist of the articles and appendices of this Plan document, the SPD, as may be amended from time to time, and any document describing the HMO options which from time to time may be offered to Participants and which are attached hereto in Appendix B. If, as to any provisions of the SPD or HMO document, the articles of this Plan document provide explicitly to the contrary, the provisions of this Plan document shall control. If there is a conflict between the provisions of any of the articles of this

Plan document and the SPD or HMO document, and such conflict involves a provision required by ERISA or the Code, the provision required by ERISA or the Code shall control. The terms of this Plan document may not enlarge the rights of a Participant to benefits available under the Plan.

ARTICLE II. ELIGIBILITY AND PARTICIPATION

Section 2.1 Eligibility.

An Employee, Former Employee, and Dependents shall be eligible to participate in the Plan as provided under the terms of the SPD as may be amended from time to time, and as may be provided in any document describing the HMO options which from time to time may be offered to Participants and which are attached hereto in Appendix B.

Section 2.2 Enrollment.

The Plan Administrator may establish procedures in accordance with the SPD, as may be amended from time to time, for the enrollment of Employees, Former Employees, and Dependents under the Plan. The Plan Administrator may prescribe enrollment forms that must be completed by a prescribed deadline prior to commencement of coverage under the Plan.

Section 2.3 Termination of Participation.

A Participant will cease being a Participant in the Plan and coverage under this Plan for the Participant shall terminate in accordance with the provisions of the SPD as may be amended from time to time, and as may be provided in any document describing the HMO options which from time to time may be offered to Participants and which are attached hereto in Appendix B.

[4] ARTICLE III. FUNDING

Section 3.1 Funding.

Notwithstanding anything to the contrary contained herein, participation in the Plan by a Participant and the payment of Plan benefits attributable to Company or Employer contributions shall be conditioned on such Participant contributing to the Plan at such time and in such amounts as the Plan Administrator shall establish from time to time ("Participant Contribution"). The Plan Administrator may require that any Participant Contributions be made by payroll deduction. Nothing herein requires the Company, an Employer, or the Plan Administrator to contribute to or under the Plan, or to maintain any fund or segregate any amount for the benefit of any Participant, except to the extent specifically required under the terms of the SPD attached hereto in Appendix B. No Participant shall have any right to, or interest in, the assets of the Company or any Employer.

Benefits are paid out of the Company's general assets, excluding HMOs and PacifiCare in-network benefits. Costs of coverage are shared by the Company and Employees.

ARTICLE IV. BENEFITS

Section 4.1 Benefits.

Benefits will be paid solely under the terms of, and in the form and amount specified in, the SPD as may be amended from time to time, and as may be provided in any document describing the HMO options which from time to time may be offered to Participants, and which are attached hereto in Appendix B.

ARTICLE V. CLAIMS

Section 5.1 Claims Procedure.

(a) Except as provided in Subsection (b), a claim for benefits shall be submitted to the claims administrator under the terms of the SPD as may be amended from time to time, and as may be provided in any document describing the HMO options which from time to time may be offered to Participants. A claim shall not be treated as having been filed until all information necessary to process the claim is submitted. In the event that a claim, as originally submitted, is not complete, the claims administrator shall notify the claimant and the claimant shall then have the responsibility for providing the missing information. If all information necessary to process a claim

is not submitted by the applicable claim filing deadline, the claim shall automatically be deemed to be denied.

[5] (b) In the event that the SPD or HMO document does not prescribe a claims procedure for benefits that satisfies the requirements of Section 503 of ERISA, the claims procedure described below shall apply.

(1) A claim shall be filed in writing and decided within ninety (90) days by the claims administrator unless special circumstances require an extension of up to ninety (90) additional days. Written notice of the decision on such claim shall be furnished promptly to the claimant and shall be written in a manner calculated to be understood by the claimant. If the claim is wholly or partially denied, such written notice shall:

(A) set forth an explanation of the specific findings and conclusions on which such denial is based, making reference to the pertinent provisions of the Plan documents;

(B) describe any additional information or material needed to support the claim and explain why such information or material, if any, is necessary; and

(C) describe the claims review procedures in subsections (2) and (3).

(2) In the event a claim for benefits is denied, or if the claimant has had no response to such claim within ninety (90) days of its submission (in which case the claim for benefits shall be deemed to have been denied) the claimant or his duly authorized representative may request a review by the Plan Administrator of such decision denying the claim.

(A) Any such request must be filed in writing within sixty (60) days after receipt by the claimant of written notice of the decision or the date such claim is deemed to be denied. Such written request for review shall contain all additional information which the claimant wishes to be considered.

(B) In pursuing this review, the claimant or his duly authorized representative:

(i) must request in writing a review of the denial;

(ii) may review pertinent documents; and

(iii) may submit issues and comments in writing.

(3) Written notice of the decision on review shall be furnished to the claimant within sixty (60) days (unless special circumstances require an extension of up to sixty (60) additional days) following the

receipt of the request for [6] review. The written notice of the decision shall include specific reasons for the decision and shall refer to the pertinent provisions of the Plan on which the decision is based. If the decision on review is not furnished within the time specified above, the claim shall be deemed to be denied on review.

Section.5.2 Exhaustion of Administrative Remedies.

No action at law or in equity may be brought to recover under this Plan until all administrative remedies have been exhausted. If a claimant fails to file a timely claim or, if a claim is denied, fails to request a review in accordance with the procedures outlined herein, such claimant shall have no rights of review and shall have no right to bring any action in any court. The denial of the claim shall become final and binding on all persons for all purposes.

Section 5.3 Action for Recovery.

No action at law or in equity may be brought for recovery under this Plan until the date on which the Participant has exhausted all appeal rights, nor more than one year after the time written proof of claim is required to be furnished.

Section 5.4 Participant's Responsibilities.

Each Participant shall be responsible for providing the Plan Administrator and/or the Company with the Participant's current address. Any notices required or permitted to be given hereunder shall be deemed given if directed to such address and mailed by regular United States mail. Neither the Plan Administrator nor the Company shall have any obligation or duty to locate a Participant.

ARTICLE VI. AMENDMENT AND TERMINATION

Section 6.1 Right to Amend.

The Board of Directors of the Company, a committee thereof, or a delegee of either, shall have the right to make at any time any amendment or modification to the Plan; but in no event shall any such amendment or modification prejudice any claim or benefit under the Plan which was incurred but not paid prior to the date of the amendment or modification. The Board of Directors has delegated to the Chief Executive Officer of the Company the authority to make any plan amendment required to bring the Plan into conformity with law or regulation.

Section 6.2 Right to Terminate.

The Board of Directors of the Company, a committee thereof, or a delegee of either, shall have the right at any time to terminate the Plan in whole or in part; but in no event shall such termination prejudice any

claim or benefit under the Plan which was incurred but not paid prior to the termination date.

[7] ARTICLE VII. ADMINISTRATION AND FIDUCIARY PROVISIONS

Section 7.1 Plan Administrator.

The Company shall be the "Plan Administrator." The Plan Administrator shall have overall responsibility for the administration of this Plan and any decisions made in accordance herewith shall be final and conclusive on all Employees. The Company may change or modify this responsibility in its sole discretion. All usual and reasonable expenses of the Plan Administrator may be paid in whole or in part by the Company and any expenses not paid by the Company shall not be the responsibility of the Plan Administrator.

Section 7.2 Powers and Duties of the Plan Administrator.

The Plan Administrator, and its designees as it relates to functions designated by the Plan Administrator, shall have such duties and powers as may be necessary to discharge its duties hereunder, including, but not by way of limitation, the following:

(a) to have complete and final discretionary authority to construe and interpret the Plan, control over the operation and administration of the Plan, including interpretation of all Plan documents, decisions concerning all

questions of eligibility to participate and the determination of the amount, manner and time of payment of any benefits hereunder. Without limitation, such decisions by the Plan Administrator and its designees as to the determination of all related or non-related questions and matters that arise under the Plan shall be final and conclusive, and there shall be no *de novo* review of any such decisions by any court. Any review of such decisions shall be limited to determining whether the decisions were so arbitrary and capricious as to be an abuse of discretion;

(b) to have control over the operation and procedures of the Plan, including prescribing procedures to be followed by Participants filing claims for benefits;

(c) to prepare and distribute, in such manner as the Plan Administrator and its designees determine to be appropriate, information explaining the Plan;

(d) to receive from the Employer and from Participants such information as shall be necessary for the proper administration of the Plan;

(e) to furnish the Employer, upon request, such annual reports with respect to the administration of the Plan as are reasonable and appropriate;

[8] (f) to receive, review and keep on file (as it deems necessary) reports of benefit payments by the Employer and reports of disbursements for expenses directed by the Plan Administrator;

(g) to exercise such authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records of the Participants and the balances which are payable under this Plan; and

(h) to appoint individuals to assist in the administration of the Plan and any other agents it deems advisable, including legal counsel, consultants and actuaries.

The Plan Administrator and its designees may rely upon any reasonable direction, or information from a Participant relating to such Participant's entitlement to benefits hereunder as being proper under this Plan, and are not required under this Plan to inquire into the propriety of any such direction or information. It is intended under this Plan that the Plan Administrator and its designees shall be responsible for the proper exercise of their own powers, duties, responsibilities and obligations under this Plan and shall not be responsible for any act or failure to act of the Employer. Neither the Plan Administrator nor the Employer make any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in this Plan.

Section 7.3 Outside Assistance and Payment of Expenses.

(a) Outside Assistance: The Plan Administrator may employ such counsel, accountants, claims administrators, consultants, actuaries and other person or persons as it shall deem advisable.

(b) Payment of Expenses: The Plan Administrator has the right to pay any Plan expenses out of existing Plan funds which in the Plan Administrator's discretion are allowable expenses under ERISA.

Section 7.4 Delegation of Powers.

In accordance with the provisions hereof, the Plan Administrator has been delegated certain administrative functions relating to the Plan with all powers necessary to enable it properly to carry out such duties.

Section 7.5 Indemnification of NonCorporate Fiduciaries and Plan Administrator.

In case the Plan Administrator or noncorporate fiduciaries of the Plan who are affiliated with the Company or an Employer as a director or officer of the Company or an Employer are involved in litigation related to the Plan, or a judgment is rendered against such parties, the Company, acting through its Board of Directors, a committee thereof, or a delegee of either, shall indemnify the Plan Administrator or

such noncorporate fiduciaries who are affiliated with the Company or an Employer as a director or officer of the Company or an Employer for any action taken in good faith in the administration of the Plan or in compliance with the requirements of the Plan.

[9] *Section 7.6 Named Fiduciaries.*

The following persons or entities are named as fiduciaries under the Plan:

(a) The Company – The Company, acting through its Board of Directors, a committee thereof, or a delegee of either, has chosen the Plan Administrator to be responsible for all fiduciary functions under the Plan, unless the function is explicitly delegated to another named fiduciary. The Plan Administrator has the authority, in its sole discretion, to construe the terms of this Plan and decide all questions of eligibility, determine the amount, time and manner of payment of any benefits and decide any other matters relating to the administration or operation of the Plan. Any such interpretations or decisions of the Plan Administrator shall be conclusive and binding.

(b) Other Named Fiduciaries:

(1) The Employer, or Employers, acting through their board of directors, shall be responsible for the funding of the Plan; provided, that the Plan's funding policy

and method shall be determined by the Company.

Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan. Any named fiduciary hereunder may, by resolution of its board of directors or pursuant to such formal procedures as it shall establish, designate persons (including third-party administrators) other than the named fiduciaries to carry out the fiduciary responsibilities under the Plan.

Section 7.7 Complete and Separate Allocation of Fiduciary Responsibilities.

It is intended that this Article VII shall allocate to each named fiduciary the individual responsibility for the prudent execution of the functions assigned to each named fiduciary. The performance of such responsibilities shall be deemed a several assignment and not a joint assignment. None of such responsibilities nor any other responsibility is intended to be shared by two (2) or more of such fiduciaries, unless such sharing shall be provided by a specific provision of the Plan or any agreement of trust. Whenever one named fiduciary is required by the Plan to follow the directions of another, the two shall not be deemed to have been assigned a shared responsibility, but the responsibility of the one giving the direction shall be deemed to be its sole responsibility, and the responsibility of the one receiving such direction shall be to

follow it insofar as such direction is on its face proper under the Plan and applicable law.

Section 7.8 Disclaimer of Liability.

Except as otherwise provided under sections 404 through 409 of ERISA, neither the Board of Directors of the Company, the Employer, the board of directors of the Employer, the trustee (if any), the Plan Administrator, nor any person designated to carry out fiduciary responsibilities [10] pursuant to this Plan shall be liable for any act, or failure to act, which is made in good faith pursuant to the provisions of the Plan.

ARTICLE VIII. EMPLOYERS

Section 8.1 Adoption of Plan.

This Plan may be adopted by an Employer, provided that such adoption is with the approval of the Company. Such adoption shall be by resolution of the Employer's governing body, a copy of which shall be filed with the Company.

Section 8.2 Administration.

As a condition to adopting the Plan, and except as otherwise provided herein, each Employer shall be deemed to have authorized the Plan Administrator to act for it in all matters arising under or with respect to the Plan and shall comply with such other terms and conditions as may be imposed by the Plan Administrator.

Section 8.3 Termination of Participation.

Each Employer may cease to participate in the Plan with respect to its Employees or Former Employees by resolution of its governing body, provided the Employer is authorized to do so by the Company, by formal written resolutions of the Company's Board of Directors (or the person, entity or group of persons appointed by the Board of Directors by action taken in accordance with its authority).

ARTICLE IX. MISCELLANEOUS

Section 9.1 Exclusive Benefit.

This Plan has been established for the exclusive benefit of Participants and except as otherwise provided herein, all contributions under the Plan may be used only for such purpose.

Section 9.2 Non-Alienation of Benefits.

No benefit, right or interest of any Participant under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law or, in the case of assignments, as permitted under the terms of the Plan. The Employer shall not be in any manner liable for or subject to the debts, contracts, liabilities, engagements or torts of any Participant entitled to benefits hereunder.

[11] *Section 9.3 Limitation of Rights.*

Neither the establishment nor the existence of the Plan, nor any modification thereof, shall operate or be construed so as to:

(a) give any person any legal or equitable right against the Plan (including any assets of the Plan) the Company or an Employer, except as expressly provided herein or required by law; or

(b) create a contract of employment with any Employee, obligate the Company or an Employer to continue the service of any Employee, or affect or modify the terms of an Employee's employment in any way, including the right of the Company or an Employer to discharge any Employee, with or without cause.

Section 9.4 Governing Laws.

The Plan shall be construed and enforced according to the laws of the state of Massachusetts, to the extent not preempted by Federal law that shall otherwise control.

Section 9.5 Severability.

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such invalid or unenforceable provision had not been included herein.

Section 9.6 Construction.

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof. Any terms expressed in the singular form shall be construed as though they also include the plural, where applicable, and references to the masculine, feminine, and the neuter are interchangeable.

Section 9.7 Expenses.

Any expenses incurred in the administration of the Plan shall be paid by the Plan, by the Company and/or by one or more Employers, according to the Company's determination.

Section 9.8 Entire Plan.

This document constitutes the entire Plan and there are no oral items or conditions to the contrary. Any change, modification or amendment to the Plan must be in writing.

[12] *Section 9.9 Other Law*

The Plan shall comply with all other state and federal law to the extent not preempted by ERISA and to the extent such laws require compliance by the Plan.

IN WITNESS WHEREOF, the Company has caused this Plan to be effective January 1, 2001, except as otherwise stated herein, to be executed by its duly authorized officer.

LIBERTY MUTUAL INSURANCE COMPANY

By: /s/ Helen ER Sayles

Title: SVP – HR & Administration

[13] LIBERTY MUTUAL MEDICAL PLAN

APPENDIX A

In addition to **Liberty Mutual Insurance Company**, the following Employers have adopted the Plan pursuant to Section 8.1:

Colorado Casualty Insurance Company

Golden Eagle Insurance Corporation

Helmsman Management Services, Inc.

Liberty Insurance Holdings, Inc.

Liberty International Agency, Inc.

Liberty Mutual Fire Insurance Company

Liberty Life Assurance Company of Boston

Liberty Northwest Insurance Corporation

National Insurance Association

Summit Consulting, Inc.

The Netherlands Insurance Company

Wausau Service Corporation

Workwell Health & Safety, Inc.

[14] LIBERTY MUTUAL MEDICAL PLAN

APPENDIX B

The following documents shall form a part of the Plan pursuant to Section 1.3 herein:

Summary Plan Description for the Liberty Mutual Medical Plan.

Any communication describing the benefits under any HMO option which from time to time may be offered to Participants.

HIPAA BUSINESS ASSOCIATE ADDENDUM

This HIPAA Business Associate Addendum ("Addendum"), effective as of April 14, 2003 (the "Addendum Effective Date"), by and between Liberty Mutual Insurance Company ("Liberty Mutual"), on behalf of the Liberty Mutual Medical Plan, a Covered Entity ("CE"), and Blue Cross and Blue Shield of Massachusetts, Inc., a Business Associate of CE, ("Associate") supplements and is made a part of the Administrative Services Account Agreement between Liberty Mutual and Blue Cross and Blue Shield of Massachusetts, Inc. effective January 1, 1995 ("Agreement").

RECITALS

A. Associate may have access to, create, or receive Protected Health Information ("PHI") in the course of performing its functions and duties under the terms of the Agreement.

B. CE and Associate intend to protect the privacy of PHI in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and privacy regulations promulgated thereunder by the U.S. Department of Health and Human Services and other applicable laws.

C. The Privacy Rule requires CE to enter into a written contract or other written agreement or arrangement with Associate that meets the applicable requirements of Title 45, Sections 164.502(e) and 164.504(e) of the Code of Federal Regulations ("CFR").

In consideration of the mutual promises below and the exchange of information pursuant to this Addendum, the parties agree as follows:

1. *Definitions.*

a. *"Business Associate"* shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 160.103.

b. *"Covered Entity"* shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 160.103.

c. *"Data Aggregation"* shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 164.501.

d. *"Designated Record Set"* shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 164.501.

e. *"Health Care Operations"* shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 164.501.

f. *"Privacy Rule"* shall mean the Standards for Privacy of Individually Identifiable Health Information set forth at 45 CFR Parts 160 and 164, Subparts A and E.

g. *"Protected Health Information" or "PHI"* shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 160.103, limited to the information created or received by the Associate from or on behalf of CE.

2. *Obligations of Associate.*

a. *Permitted Uses and Disclosures.* Associate may use and/or disclose PHI to perform its obligations under the Agreement if such use or disclosure would not violate the Privacy Rule if done by CE. Notwithstanding the foregoing, Associate may also use or disclose PHI in accordance with Section 2.b. below.

b. *Additional Permitted Uses and Disclosures.* Associate may:

(i) Use PHI for the proper management and administration of Associate's operations or to carry out the legal responsibilities of the Associate;

(ii) Disclose PHI for the proper management and administration of Associate's operations or to carry out the legal responsibilities of Associate, provided that:

- The disclosures are required by law, or
- Associate obtains reasonable assurances from the person to whom the information is disclosed that said information will remain confidential and be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies Associate of any instances of which he or she is aware in which the confidentiality of the information has been breached;

(iii) Provide Data Aggregation services to the Plan as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B);

(iv) Report violations of law to appropriate federal and state authorities, consistent with 45 C.F.R. § 164.502(j)(1); and

(v) Use and disclose PHI as permitted or required by law, including but not limited to disclosing PHI for medical research studies in accordance with federal law.

c. *Appropriate Safeguards*. Associate shall use appropriate safeguards to prevent the use or disclosure of PHI other than as permitted by the Agreement and this Addendum.

d. *Mitigation*. Associate shall mitigate, to the extent practicable, any harmful effect that is known to Associate of a use or disclosure of PHI by Associate in violation of the Agreement and this Addendum.

e. *Reporting of Improper Use or Disclosure*. Associate shall promptly report to CE any use or disclosure of PHI other than as provided for by the Agreement and this Addendum of which Associate becomes aware. As of the compliance date for the HIPAA Security Standards Rule (45 C.F.R. Parts 160 and 164, Subpart C), Associate agrees to notify Sponsor of any Security Incident of which it becomes aware as required by the Security Rule.

f. *Associate's Agents*. Associate shall ensure that any agents of Associate, including subcontractors, to whom it provides PHI agree in writing to restrictions

and conditions comparable to those that apply through this Addendum to Associate with respect to such PHI.

g. *Access to Protected Information.* Associate shall make PHI in Designated Record Sets available to an individual who is the subject of such PHI for inspection and copying in accordance with 45 CFR Section 164.524.

h. *Amendment of PHI.* Associate will respond to requests for amendment(s) to PHI in a Designated Record Set in accordance with the terms of 45 CFR Section 164.526.

i. *Accounting Rights.* Upon request by an individual who is the subject of PHI for an accounting of disclosures of such PHI, Associate shall make available to such individual the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528. Associate will document such disclosures of PHI and information related to such disclosures as would be required for CE to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. Section 164.528.

j. *Governmental Access to Records.* Associate shall make its internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining CE's compliance with the Privacy Rule.

k. *Minimum Necessary*. Associate shall only request, use and disclose the minimum amount of PHI necessary to accomplish the purpose of the request, use, or disclosure.

l. *Electronic Data Interchange*. Associate shall be capable of transmitting electronic data for which transaction standards have been promulgated in compliance with the HIPAA Electronic Transactions Rule, 45 CFR Parts 160 and 162, as of the effective date of such Rule, including any applicable implementation periods, and shall to the extent possible transmit electronic data in accordance with such Rule and the HIPAA contingency plan adopted by Associate.

m. *Security Standards*. Associate shall implement processes and safeguards to secure PHI in compliance with the Security Standards Rule (45 CFR Parts 160 and 164, Subpart C), as of the effective date of such Rule, including any applicable implementation periods. . If Associate is required by law to perform a function or activity on behalf of, or provide a service to, CE, CE and Associate will, at the request of either party, enter into good faith negotiations to permit Associate to create, receive, maintain, and/or transmit electronic PHI on CE's behalf to the extent necessary to comply with the legal mandate without meeting the requirements of this subsection 2(m) or subsection 2(e) above, in accordance with 45 C.F.R. § 164.314(a)(2)(ii)(B).

3. *Obligations of CE.*

a. CE will notify Associate immediately in writing of any limitation(s) in CE's notice of privacy practices in accordance with 45 C.F.R. § 164.520, to the extent that such limitation(s) may affect Associate's use or disclosure of PHI.

b. CE will notify Associate immediately in writing of any restriction to the use or disclosure of PHI that CE has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Associate's use or disclosure of PHI.

c. CE will notify Associate immediately in writing of any changes in, or revocation of, permission by an individual to use or disclose PHI, to the extent that such changes may affect Associate's use or disclosure of PHI.

d. CE will not request that Associate use or disclose Protected Health Information in any manner that would be impermissible under the Privacy Rule if done by CE, provided that CE may request that Associate use or disclose Protected Health Information in accordance with paragraphs 2.a. and 2.b. above and paragraph 3.f. below.

e. CE shall only request from Associate the minimum amount of PHI necessary to accomplish the purpose of the request.

f. CE authorizes and permits Associate to disclose PHI to the Plan Sponsor. CE and Plan Sponsor represent that (i) the Plan documents have been

amended in accordance with 45 CFR 164.504(f)(2); (ii) the CE has received a certification by the Plan Sponsor that the Plan documents have been amended to comply with the requirements of 45 CFR 164.504(f) and Plan Sponsor will appropriately safeguard and limit the use and disclosure of PHI; (iii) the statement required by 45 CFR 164.520(b)(1)(iii)(C) has been included in the notice of privacy practice. CE will provide Associate with a written list of persons identified in the Plan document, as may be amended from time to time, as persons authorized to have access to PHI to carry out plan administration functions. The CE will provide Associate with an updated version of the list, in writing, immediately following any amendment to the Plan documents that changes the persons authorized to have access to Protected Health Information. Associate will disclose PHI in accordance with this subsection 3(f) only to persons included on the list provided to Associate.

4. *Termination.*

a. *Material Breach.* A breach by Associate of any material provision of this Addendum shall constitute a material breach of the Agreement and shall provide grounds for immediate termination of the Agreement.

b. *Reasonable Steps to Cure Breach.* If CE knows of a pattern of activity or practice of Associate that constitutes a material breach or violation of the Associate's obligations under the provisions of this Addendum and does not terminate the Agreement

pursuant to Section 4(a), then CE shall provide an opportunity for Associate to take reasonable steps to cure such breach or end such violation, as applicable. If efforts to cure such breach or end such violation are unsuccessful, CE shall either (i) terminate the Agreement, if feasible or (ii) if termination of the Agreement is not feasible, CE shall report Associate's breach or violation to the Secretary of the Department of Health and Human Services.

c. *Effect of Termination*. Upon termination of this Agreement, Associate will

(i) Retain all Protected Health Information in its possession in accordance with Associate's record retention policies and applicable law;

(ii) Extend the protections of this Addendum to the retained Protected Health Information; and

(iii) Notwithstanding any interpretation of section 4.c.ii to the contrary, comply with the obligations set forth in sections 2.g., 2.h., 2.i., and 2.j. provided that CE agrees to reimburse Associate for the reasonable costs associated with such obligations.

5. *Indemnification*. Associate shall indemnify and hold harmless CE and Liberty Mutual, and its parents, subsidiaries, and affiliates, and their respective directors, officers, employees, attorneys, and agents, past and present, from any and all claims, damages, suits, losses, penalties, demands, costs, liabilities, settlements, attorney's fees, judgments, and expenses of any kind arising from, in connection with, or related

to the acts or omissions under this Addendum of Associate or any of its subcontractors, employees, representatives, or agents. CE shall indemnify and hold harmless Associate, and its subsidiaries and affiliates, and their respective directors, officers, employees, attorneys, and agents, past and present, from any and all claims, damages, suits, losses, penalties, demands, costs, liabilities, settlements, attorney's fees, judgments, and expenses of any kind arising from, in connection with, or related to the acts or omissions under this Addendum of CE or any of its subcontractors, employees, representatives, or agents.

6. *Amendment*. The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of the Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to amend this Addendum from time to time as is necessary for CE to comply with the requirements of Privacy Rule and HIPAA. The parties understand and agree that CE must receive satisfactory written assurance from Associate that Associate will adequately safeguard all PHI. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA, the Privacy Rule or other applicable laws and regulations.

7. *No Third Party Beneficiaries*. Nothing express or implied in this Agreement is intended to confer, nor

shall anything herein confer, upon any person other than CE, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

8. *Effect on Agreement.* Except as specifically required to implement the purposes of this Addendum, or to the extent inconsistent with this Addendum, all other terms of the Agreement shall remain in force and effect.

9. *Interpretation.* The parties agree that any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the Privacy Rule.

10. *Survival.* This Addendum will survive termination of the Addendum and the Agreement solely with respect to Protected Health Information retained in accordance with section 4.c. above for so long as such information is retained. In addition, section 5 shall survive termination of this Addendum.

11. *Regulatory References.* A reference in this Addendum and in the Agreement to a section in the Privacy Rule means the section as in effect or as amended.

12. *Notices.* Any notices required under this Addendum shall be in writing and delivered in person or mailed by registered or certified mail or by overnight courier to the following addresses:

To CE: Liberty Mutual Insurance Company,
On Behalf of the Liberty Mutual Medical Plan
175 Berkeley Street
Boston, MA 02117
Attention.: Mgr Health Plans

To Associate: Blue Cross and Blue Shield of Massachusetts, Inc.
Landmark Center
410 Park Drive
Boston, Massachusetts 02215-3326
Attention: Contracts Administration

IN WITNESS WHEREOF, the parties hereto have duly executed this Addendum as of the Addendum Effective Date.

/s/ Helen ER Sayles
Liberty Mutual Insurance Company
of [sic] behalf of Liberty Mutual Medical Plan

/s/ Stephen R Booma
Blue Cross and Blue Shield of Massachusetts, Inc.

AMENDMENT TO HIPAA BUSINESS ASSOCIATE ADDENDUM

This Amendment entered into by and between Blue Cross and Blue Shield of Massachusetts, Inc. ("Associate") and Liberty Mutual Group Inc. ("Liberty Mutual") on behalf of the Liberty Mutual Medical Plan ("CE") is effective February 17, 2010 ("Amendment Effective Date") and is made part of that certain HIPAA Business Associate Addendum between the parties ("Addendum") that forms part of that certain Administrative Services Agreement ("Agreement") effective January 1, 1995 entered into by and between the Liberty Mutual and Associate.

A. Whereas the parties previously have entered into the Addendum to protect the privacy and provide for the security of PHI in compliance HIPAA and the HIPAA Regulations and other applicable laws;

B. Whereas the parties now wish to amend such Addendum to comply with the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("HITECH") and HITECH regulations and guidance;

Now, therefore, in consideration of the mutual promises contained herein and in the Agreement, the parties agree to supplement the Addendum and Agreement by adding the following new provisions:

1. Definitions.

a. "Breach" shall have the meaning given to such term under HITECH § 13400 and any HITECH regulations and guidance including, but not limited to, 45 CFR § 164.402.

b. "Electronic Health Record" shall have the meaning given to such term under HITECH § 13400.

c. "Unsecured Protected Health Information" or "Unsecured PHI" shall have the meaning given to such term under HITECH regulations and guidance including, but not limited to, 45 CFR § 164.402.

d. Any terms used, but not otherwise defined, in the Addendum and this Amendment shall have the same meaning as those terms have under HIPAA, HITECH, and the HIPAA Regulations.

2. HITECH Standards and Requirements.

Notwithstanding any other provision in this Amendment, no later than February 17, 2010, unless a separate effective date is specified by applicable law or this Amendment for a particular requirement (in which case the separate effective date shall be the effective date for that particular requirement), Associate shall comply with HITECH and HITECH guidance, regulations, standards, and requirements, including but not limited to:

(i) individual requests for restrictions on use or disclosure of PHI to health plans for payment or health care operations purposes when the

individual has paid the provider out of pocket in full consistent with HITECH § 13405(a);

(ii) compliance with the requirements regarding "minimum necessary" consistent with HITECH § 13405(b); Associate understands and agrees that the definition of "minimum necessary" is in flux and shall monitor guidance issued by the Secretary with respect to what constitutes "minimum necessary;"

(iii) effective as of the compliance date set forth in HITECH § 13405(c) or as of the separate compliance date set forth in HITECH regulations, the requirements regarding accounting of certain disclosures of PHI maintained in an Electronic Health Record under HITECH § 13405(c) to the extent Associate discloses any PHI maintained in an Electronic Health Record;

(iv) the prohibition on sales of PHI without authorization unless an exception applies consistent with HITECH § 13405(d);

(v) the provision of access to certain information in electronic format consistent with HITECH § 13405(e);

(vi) the requirements under HITECH § 13406 relating to marketing, the prohibition on receiving remuneration for certain communications that fall within the exception to the definition of marketing unless permitted by HITECH § 13406, and the provisions relating to opt-out of fundraising communications; and

(vii) compliance with each of the Standards and Implementation Specifications of 45 C.F.R.

§§ 164.308 (Administrative Safeguards), 164.310 (Physical Safeguards), 164.312 (Technical Safeguards) and 164.316 (Policies and Procedures and Documentation Requirements).

If Associate knows of a pattern of activity or practice of CE that constitutes a material breach or violation of CE's obligations under the provisions of the Addendum or Amendment, Associate shall provide an opportunity for CE to take reasonable steps to cure such breach or end such violation, as applicable. If efforts to cure such breach or end such violation are unsuccessful, Associate shall either (i) terminate the Agreement, if feasible or (ii) if termination of the Agreement is not feasible, Associate shall report CE's breach or violation to the HHS Secretary.

Associate acknowledges that Associate is subject to same civil and criminal penalties as CE if Associate violates the HIPAA privacy and security requirements as set forth in the Business Associate Addendum between the parties including this Amendment.

3. Notification of Breach of Unsecured PHI.

In addition to any other notification and reporting obligations in the Agreement and Addendum, Associate shall notify CE of any significant impermissible acquisition, access, use or disclosure of PHI. Associate shall notify CE of any Security Incident and any Breach of Unsecured PHI which Associate "discovers," consistent with HITECH regulations including 45 CFR § 164.402 and 45 CFR § 164.410, without

unreasonable delay and in no case later than five (5) business days after such discovery.

Associate shall take (i) prompt corrective action to cure any such deficiencies, (ii) any action pertaining to such impermissible acquisition, access, use or disclosure or Breach of Unsecured PHI required by applicable federal and state laws and regulations, and (iii) indemnify and hold harmless CE and Liberty Mutual for any claims, costs, fines, penalties, and expenses, including the cost of notification and on-going monitoring services, arising from any such impermissible acquisition, access, use or disclosure of PHI or Breach of Unsecured PHI.

If the parties determine there is a reportable Breach of Unsecured PHI, Associate will provide all HITECH-required notices to affected individuals, in accordance with all applicable requirements and timeframes under HITECH and the HITECH regulations. Associate will provide CE a copy of any proposed notice or communication before providing the notice or communication to individuals.

Associate shall maintain all documentation required under 45 CFR § 164.414(b).

All other terms and conditions of the Agreement and Addendum shall remain in full force and effect. In the event of any conflict between the terms and conditions of this Amendment and the terms and conditions of the Agreement and Addendum, this Amendment shall prevail.

IN WITNESS WHEREOF, the parties hereto have duly executed this Amendment as of the Amendment Effective Date.

/s/ Helen ER Sayles	/s/ Timothy J. O'Brien
Liberty Mutual Group Inc. on behalf of Liberty Mutual Medical Plan	2/18/10 Blue Cross and Blue Shield of Massachusetts, Inc.

[LOGO] **BlueCross BlueShield of Massachusetts**

The Health Services Company™

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Blue Cross and Blue Shield Association

ADMINISTRATIVE SERVICES AGREEMENT entered into by and between Blue Cross and Blue Shield of Massachusetts, Inc. and Liberty Mutual Insurance Company

Blue Cross and Blue Shield of Massachusetts, Inc. (Blue Cross and Blue Shield) will administer health care benefits for your covered employees and their covered dependents according to the health care benefits detailed in your ERISA plan documents attached to and incorporated in this Agreement as Attachment A. We will administer benefits for these members as long as they meet the eligibility requirements of your ERISA plan documents and as long as the applicable charges are paid.

In this Agreement, the terms we, us, and our refer to Blue Cross and Blue Shield. The terms you and your refer to the account that has entered into this Agreement as shown by the authorized signatures in Section 10 below.

You, on your own behalf and on behalf of your covered employees, hereby expressly acknowledge your understanding that this Agreement constitutes a contract solely between you and Blue Cross and Blue Shield of Massachusetts, Inc. (Blue Cross and Blue Shield) which administers both Blue Choice Plan 2 and Select Blue for Pennsylvania Employees, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Blue Cross and Blue Shield to use the Blue Cross and Blue Shield Service Marks in the Commonwealth of Massachusetts, and that Blue Cross and Blue Shield is not contracting as the agent of the Association. You, on your own behalf and on behalf of your covered employees, further acknowledge and agree that you have not entered into this Agreement based upon representations by any person other than Blue Cross and Blue Shield and that no person, entity, or organization other than Blue Cross and Blue Shield will be held accountable or liable to you for any of Blue Cross and Blue Shield's obligations to you created under this Agreement. This paragraph will not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield other than those obligations created under other provisions of this Agreement.

Section 1. Term of This Agreement

This Agreement will be effective for the term stated in Attachments A, B and C unless terminated

as described in Section 8 below, and will be automatically extended from year to year on your anniversary/renewal date. Attachments A, B and C are incorporated as part of this Agreement and may be amended from time to time upon mutual written agreement. We will deliver your renewal rates 180 days prior to your anniversary/renewal date.

The initial term of this Agreement begins on January 1, 1995.

Section 2. General Terms of This Agreement

You will be solely responsible for complying with all applicable provisions of the Employee Retirement Income Security Act of 1974, as amended. This includes the fiduciary responsibilities of structuring your health benefit plans and maintaining adequate funding to support these plans. You will also be responsible for providing your covered employees with copies of the ERISA plan documents describing your health benefit plans and with copies of a summary brochure of benefits, limitations, exclusions and waiting periods.

You will be solely responsible for any health care benefits or services that you must provide under any applicable employer's liability or indemnification law or under any workers' compensation act.

You will be solely responsible for collecting any charges that you assess for your employees.

In the event that we are subject to federal or state laws or regulations mandating a change in the benefits of your health benefit plans or in the eligibility of covered employees and their covered dependents, we will implement such mandatory change. If your charges are to be increased, we will give you 60 days prior written notice of prospective adjustments. When you are subject to federal or state laws or regulations, these changes will be effective on the date you specify, provided we receive prior written notice. You agree to hold us harmless for any charges, including legal fees, judgments, administrative expenses and benefit payment requirements, that may result at any time arising from or in connection with your self-insured ERISA health benefit plan or due to your failure to comply with any laws or regulations, unless caused by an error on our part and/or by dishonest, fraudulent or criminal conduct by us or our agents. This includes, but is not limited to, any non-compliance with mandated benefits provisions and the Medicare secondary payor provisions. This indemnification provision will continue in effect after termination of this Agreement for any reason.

You agree to indemnify and hold us harmless for any taxes and assessments, including penalties and interest, or any other amounts legally levied based on the terms of this Agreement. We agree to notify you of any action as soon as possible. This provision applies to any amounts imposed, now or later, under the authority of any federal, state or local taxing jurisdiction.

This provision will continue in effect after termination of this Agreement for any reason.

This Agreement may be amended only by written agreement of both parties. A waiver for any breach of this Agreement will not be construed to be a continuing waiver for a similar breach. Such a waiver must be in writing and signed by authorized representatives of both parties to be effective.

We will not use or publish in any of our advertisements, external publications, client lists, press releases or similar statements your name, logo, or other name or marks associated with you without your prior written consent. Notwithstanding the foregoing, we may, in conversation with particular prospective customers, make reference to the fact that you selected us as one of your health care providers (provided in the statements with respect to you are truthful and not misleading); and we may (without your prior consent), in responses to requests for proposal in individual bid situations, include your name in a listing of employers who have selected us as one of your health care providers for your employees.

Section 3. Enrollment and Membership Requirements

The effective date or termination date of a covered employee's (and his or her dependents') membership will be the date you specify in written notice as long as that date is no more than 60 days before the date we receive your written notice and you pay the

applicable charges. This 60-day retroactivity provision will apply except as otherwise required by federal law or specified in the ERISA plan documents for your health benefits plans.

When a member is no longer eligible for group coverage, he or she may have the option to continue coverage as provided by state or federal law. You must provide all required continuation of coverage notices to the member.

Section 4. Benefits/Claims Liability

We will administer benefits based on your ERISA plan documents that are in effect for the covered member at the time the services are furnished. No action may be brought against us for failure to provide benefits unless brought within two years from the time the cause of action arises.

We will use the degree of ordinary care and reasonable diligence in the exercise of our powers and duties under this Agreement that an administrator of claims under an insured or uninsured employee benefit plan would use acting in like circumstances and familiar with such matters.

You must provide us with a current and updated listing of covered employees. You will be responsible for all costs and expenses associated with failure to maintain an accurate and current listing with us, unless such costs and expenses are due to an error on our part.

We will make recoveries for you through application of the subrogation, coordination of benefits, and workers' compensation provisions of your ERISA plan documents describing your health benefit plans to the extent allowed by contractual agreements with providers. Recoveries, if any, will be credited to you at the time of such recovery.

Upon the effective date of this Agreement, and for the duration of this Agreement, we will have in place a quality assurance program designed to provide quality medical services and care in an efficient and cost effective method to each covered member.

We represent and warrant that beginning with the effective date of this Agreement and for the duration of this Agreement, our quality assurance program is reasonable and customary for similarly situated companies in the same or like business as us and that we know of no material deficiencies in our quality assurance program, nor have any material deficiencies been alleged by any person or entity.

Effective January 1, 1998, we will pursue recoveries of fraudulent claims identified through our fraud and abuse detection activities. Our costs for fraud and abuse prevention and detection are included in the administrative charges described in the applicable Attachments to this Agreement. However, investigative costs to pursue recoveries are not. In the event we pursue and obtain a recovery of fraudulent claims, we may retain a portion of the recovery to support our costs. The balance of the recovery will be

credited to you at the time of the recovery. We will not charge you for our investigative costs if we do not obtain a recovery.

Effective January 1, 1999, we may contract with a consultant to identify and pursue claim recoveries through various types of specialized audits. In the event that such a claim recovery is obtained by the consultant, we will retain, on a claim by claim basis, the portion of the recovery that we reimburse to the consultant for these services. The balance of the recovery will be credited to you. We will not charge you for our costs if our consultant does not obtain a recovery.

You will be liable for claims incurred after a member's termination date until the date we receive your electronic or written notice of the member's termination date. You will also be liable when, under certain conditions detailed in your ERISA plan documents describing your health benefit plans, benefits continue beyond the termination date.

We agree to indemnify you and hold you harmless against any and all loss, liability, damage, expense, cost or obligation (including reasonable attorney's fees) with respect to this Agreement resulting from or arising out of the dishonest, fraudulent or criminal acts of our employees or agents acting alone or in collusion with others, or for that portion of such loss, liability, damage, expense, cost or obligation that an arbitrator determines was the result of or arose out of acts of our employees or agents in providing such

service under this Agreement not in compliance with the provisions as described above. This provision will survive termination of this Agreement.

Both parties desire that any dispute concerning this Agreement be handled out of court. Accordingly, the parties agree that any such dispute will, as the parties' sole and exclusive remedy, be submitted to expedited arbitration in Suffolk County, Massachusetts before an experienced health care arbitrator licensed to practice law in Massachusetts and selected in accordance with the standard rules of the American Arbitration Association (AAA). Both parties agree to waive any right of appeal to a court following arbitration. Should either party start any legal action or administrative proceeding against the other with respect to any claim waived by this Agreement, or pursue any method of resolution of a dispute other than mutual agreement of the parties or arbitration, then all damages, costs, expenses and attorney's fee incurred by the other party as a result will be the responsibility of the party bringing the suit or starting the proceeding.

Section 5. Reports

We will provide you with a paper copy of a monthly claims listing. This claims listing will include those claims we have paid in a specified month and year, itemized by identification number, patient name, date of service, claim number, and paid amounts. You may elect to receive the monthly claims

listings in an alternative format, such as on tape, in a mutually agreed upon format at an additional charge as described in the Attachment for Paid Claims Information. Signing the Attachment for Paid Claims Information will initiate your request for production of this type of claims listing and that Attachment will be incorporated as part of this Agreement.

Other information provided under this Agreement may include paper copies of rate quotations, membership lists and standard cost and utilization reports.

If you enter into a separate confidentiality and indemnification agreement with us to the extent permitted by law, we will also provide information that is available as to diagnosis, treatment or prognosis with respect to any physical or mental condition and/or treatment of covered members.

You will use any information we make available solely for the purpose of administering your health care plans under this Agreement and as otherwise authorized by the covered member or the covered member's representative. You agree to hold us harmless for any claim, action or loss that may arise at any time in the future out of your unauthorized use of this information. Furthermore, if you use the information for another purpose, we will consider that action material breach. This Agreement will then be subject to immediate termination.

We will provide you with a monthly reserve estimate for incurred but not processed claims.

Section 6. Audits

If you dispute a charge that is included on your monthly claims listings, you must notify us of those amounts you dispute. You must still pay us the amount due us. If we verify that the charges are not your responsibility, we will credit you with the disputed amount.

When you dispute claim payments, you have the right at any time during regular business hours to review the data that supports our claim payments. Requests for this information must be made to us in writing. For disputed claim requests received on or after January 1, 1997, you must pay us an amount equal to 10% of the paid claim amount if we receive your request more than two years from the date the disputed claim was paid or denied.

Each year, you have the right to request, at your expense, a comprehensive audit of our claim payment records to ensure that our administration of the covered health care benefits is performed according to the terms of this Agreement and your ERISA plan documents describing your health benefit plans. These audits will be conducted only for claims processed within the previous two years of the date the audit is requested and according to the audit procedures we agree to with you prior to the start of the audit. We maintain auditable documentation for only a two-year period. Confirmed claim payment errors identified in the audit will be promptly corrected on a claim by claim basis under the normal recovery

process. You are not permitted to use extrapolation methodologies to calculate the financial impact of errors in a population of claim payments on the basis of a sample drawn from that population.

Indemnification. You agree to indemnify and hold us harmless from any loss, liability, damage or expense (including reasonable attorney's fees) which may result from any claim, demand, lawsuit or preceding arising out of the disclosure of information by us to you or your employees or agents in connection with the audit, or your failure or your employees or agents failure to maintain the confidentiality of any personal information in the claim records reviewed.

Auditor Qualifications. We require that you enter into an Audit and Confidentiality Indemnification Agreement with us prior to your audit. You will utilize individuals to conduct audits on your behalf who are qualified by appropriate training and experience for such work. You will also require them to perform their review in accordance with published administrative safeguards or procedures against unauthorized disclosure, in the audit report or otherwise, of any individually identifiable information (including health care information) contained in the claim records to be audited and will not make or retain any record of patient identifying information concerning treatment of drug or alcohol abuse, mental health conditions or AIDS in connection with any audit. If you use a firm to do the audit, it must be a mutually acceptable CPA firm or nationally recognized consulting

firm and that firm must enter into an Audit and Confidentiality Indemnification Agreement as well.

Identification of Audit Sample. During the audit, the auditors will provide a listing of the transactions selected for testing and the guarantee (payment dollar accuracy or overall accuracy) for which each item is being tested.

Closing Meeting. The auditors will identify, in writing, sample items which they believe to be in error and the nature of the error. This will provide the basis for a discussion to resolve disagreement and a summarization of the audit findings.

Random Selection of Audit Sample. The sample must be selected based on a random sampling methodology. Certain transactions defined by diagnosis (for example, mental conditions or AIDS/ARC) are excluded from the population because of legal requirements.

Size of Audit Sample. The audit sampling methodology must be thoroughly understood and endorsed for appropriateness in our business environment. A statistically valid sample size usually is from 100 to 150 claims, depending upon the universe from which the sample will be selected. (Generally, the sample is based on a 95% confidence level with an expected error rate not over 3% and precision of plus or minus 3%.) If the size of the sample is significantly outside of this range, you may be responsible for an additional administrative fee.

Section 7. Reopenings

You will conduct regular annual enrollment periods on your anniversary/renewal date. This will be done in order to change rates and/or benefits and, when you offer benefit choice to your employees, to give them an opportunity to select an alternative health benefit plan for the next policy year.

Section 8. Termination of This Agreement

This Agreement may be terminated upon written notice for material breach, fraud or misrepresentation, subject to notice and right to cure within 21 days, except if a longer period is provided under the terms of this Agreement.

This Agreement may also be terminated by either party as of the last day of any policy year upon 120 days prior written notice to the other.

This Agreement will be terminated in the event that you do not pay to us the total of all charges you owe us, as described in the applicable Attachments to this Agreement. If full payment is not received on or before the due date, we will suspend all claim payments as of the last date through which you have paid charges to us. If full payment is not received within 30 days after the due date, we will terminate this Agreement as of the last date through which you have paid charges to us.

This Agreement will automatically terminate in the event that you file for bankruptcy. In this case,

termination will be effective on the date you file for bankruptcy. You must accept a premium financial arrangement in order to continue health care coverage with us.

In the event that we file for bankruptcy, we become insolvent or we are placed in voluntary or involuntary receivership or rehabilitation, you will have the option to terminate this Agreement by providing us with written notice.

Upon termination, you may elect to have us continue our administration of any incurred but unreported claims and accrued but unpaid claims by paying us as described in Attachment A.

Section 9. Notices

Notices under this Agreement will be mailed by first class mail (postage paid) or delivered by hand to your address as listed in your annual renewal package and to our address as follows:

Blue Cross and Blue Shield of Massachusetts, Inc.
100 Summer Street
Boston, MA 02110

A notice will be deemed received by the close of business on the fifth business day after the date it is mailed.

Section 10. Acceptance

This Agreement and Attachments A, B and C and the provisions in your annual renewal package that

are referenced in your Agreement constitute both parties' entire understanding and supersedes all prior representations and understandings, whether oral or written, and will be governed by and construed according to the laws of the Commonwealth of Massachusetts.

This Agreement has been executed in duplicate by the authorized representatives whose signatures appear below:

Blue Cross and Blue Shield of Massachusetts, Inc.	**Liberty Mutual Insurance Company**
/s/ Donna L. Morris	Name:/s/ Helen ER Sayles
Donna L. Morris, Director Contracts Development	
/s/ W. Patrick Hughes	Title:Sr. Vice President HR & Admin
W. Patrick Hughes, Senior Vice President Sales, Marketing and Product Management	
Dated: 8/9/99	Dated: 11/22/99

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AA ASC 196 NONSTD

[LOGO] **BlueCross BlueShield of Massachusetts**

The Health Services Company™

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Blue Cross and Blue Shield Association

Attachment A
For Administrative Services Agreement

Health Benefit Plans

For the term January 1, 1995 through December 31, 1999, the following documents describe your health benefit plans:

Managed Care Plans:

Liberty Mutual Medical Plan referred to as Point-of-Service Plan in the Summary Plan Description, as the same has been and may be amended from time to time.

Acceptance

This Agreement has been executed in duplicate by the authorized representatives whose signatures appear below:

Blue Cross and Blue Shield of Massachusetts, Inc.	**Liberty Mutual Insurance Company**
/s/ Donna L. Morris	Name: /s/ Helen ER Sayles
Donna L. Morris, Director Contracts Development	

/s/ W. Patrick Hughes
W. Patrick Hughes, Senior Vice President Sales, Marketing and Product Management

Dated: _____

Title: Sr. Vice President HR & Admin

Dated: 11/22/99

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ASC ATTA 196

[LOGO] **BlueCross BlueShield of Massachusetts**

[redacted]™

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Attachment B
For Administrative Services Agreement

Cost Reimbursement
With Level Weekly Payments

For the term January 1, 1995 through December 31, 1999, the following provisions will apply:

Your Health Care Costs

Under this Cost Reimbursement arrangement, you will pay all health care costs incurred by covered members during the term of this Agreement and paid by us. Your health care costs consist of claim payments incurred by your members and which are covered under the terms of your Plan. Claim payments are the amounts we pay providers for your members' health care benefits when billed by the provider. We will administer your health care benefits based on the plan documents describing the health benefit plans you offer (see Attachment A) and on contractual agreements with providers. (We will administer your health care benefits for services furnished by covered non-contracting providers based on your plan documents and consistent with the providers' charges.) You will pay all claim payments incurred by members during the term of this Attachment.

Claim Payments and Provider Settlements. In Massachusetts, under fee-for-service contractual agreements with providers, claim payments reflect the rate of payment in effect at the time the claim is paid, but this rate does not include either positive or negative effects of any later contractual settlements with the providers. You will not be billed for or receive credit for any such settlements.

Effective on and after January 1, 1997, your administrative charge will include a credit or debit that reflects an average member allocation of the contractual settlement monies we project will be attributable to claims incurred over the term of this Agreement. We will select an independent auditor to review and approve this projection annually. You agree that this credit is the full and final amount you will receive from us related to any contractual settlements with providers attributable to claims incurred over the term of this Agreement.

Claim payments for Massachusetts acute care hospital and ambulatory surgery center services include an additional portion that is paid by Blue Cross and Blue Shield to the Massachusetts Uncompensated Care Pool in accordance with state law.

Additional Health Care Costs. For the managed care plans offered under this Agreement, you must pay certain additional health care costs incurred by your members during the term of this Agreement. These additional health care costs consist of the following payments to providers as applicable

under provider agreements: capitation payments and member management fees. Member management fees are set for certain periods of time based on the provider's performance and vary from provider to provider. They compensate providers for member management functions and reward them for effective member management.

In addition, for covered services and supplies furnished in Massachusetts, claim payments also include Blue Cross and Blue Shield health center encounter services and the amount we withhold from claim payments to providers when applicable under provider agreements. When a provider's contract includes provisions for withholding some of his or her claim or capitation payments and/or provisions for provider repayment of excess claim payments (including risk-sharing arrangements), we pay the withheld amounts to the provider if the provider's aggregate performance meets or is below the target we set.

Effective on and after January 1, 1997, if, after we settle with providers, any of the withheld funds are not paid to providers or we receive any repayments of claims payments in excess of the target, we will refund to you an aggregate pro rata share of these amounts. We will let you know the method we use to calculate your aggregate pro rata share (if any). In addition, if after settlements, providers earn payments in excess of the withheld amounts, we will debit you for your share of the excess payments. We will let you know the method we will use for allocating this debit.

Out of State Health Care Costs. If your member incurs health care costs outside of Massachusetts, in most other states, as in Massachusetts, claim costs reflect the rate of payment in effect at the time the claim is paid, but do not include either positive or negative effects of any later settlements with the providers. However, other Blue Cross and Blue Shield Plans may operate differently; for example, some Blue Cross and Blue Shield Plans do directly reflect both positive and negative effects of provider discounts or settlements, and some Plans retain a percentage of their discount or have other arrangements with providers. Our bills to you reflect the bills we receive from the other states' Plans. We will not bill you more than the other states' Plans bill us. In addition, we will not be responsible for determining the basis of provider payments passed through to us by any other Blue Cross and Blue Shield Plan.

Access Fees for Out of State Claims. Effective on and after January 1, 1996, for covered services and supplies furnished outside Massachusetts, we may be charged an "access fee" by the local Blue Cross and Blue Shield Plan. This fee is for access to the local Plan's negotiated payment rates and the resulting savings available to you and to members. (The access fee may be up to 10% of the local Plan's discount with a $2,000 cap per claim. We will notify you in writing in the event these limits are ever changed.) A Plan will charge an access fee only if its provider agreements prohibit billing members for amounts in excess of the negotiated payment rate. When we are charged

an access fee, we will pass the charge along to you as a claims expense. If we receive an access fee credit, we will give you a claims expense credit. Access fees are considered a claims expense because they represent claims dollars we were unable to or, in the case of a credit, able to avoid paying. Instances may occur in which we do not pay a claim (or pay only a small amount) because the amounts eligible for payment were applied to the deductible or coinsurance. If the local Blue Cross and Blue Shield Plan's arrangement with its provider allows the negotiated payment rate to apply when the amount is fully or mostly a patient obligation, we will pay the local Plan's access fee and pass it along to you as a claims expense even though we paid little or none of the claim.

Termination. If your Agreement with us is terminated, you with still be liable for all health care costs (including the amount set aside for provider incentives where applicable) incurred prior to the termination date but paid by us after the termination date. We will continue to be paid by the ACH credit transaction process set forth below. Both parties will agree to the amount of this weekly payment amount prior to the termination date. This amount will be adjusted upon agreement of both parties.

Administrative Charges

To your health care costs, we will add an administrative charge to support our administration of benefits. Your administrative charge is a fixed dollar

amount for each covered employee for each month. Your administrative charge is:

- $23.75 for each covered employee for the term January 1, 1995 through December 31, 1995.
- $24.70 for each covered employee for the term January 1, 1996 through December 31, 1996.
- $24.25 for each covered employee for the term January 1, 1997 through December 31, 1997.
- $32.74 for each covered employee for the term January 1, 1998 through December 31, 1998.
- $34.70 for each covered employee for the term January 1, 1999 through December 31, 1999.

Your administrative charge is considered "fully incurred." This means that the total administrative charges that you pay during the term of this Attachment support our administration of benefits for all health care costs incurred during any term of your Administrative Services Agreement. We will not bill you for any additional administrative charges to support our administration of continuing or run-off health care costs that we pay after the termination date.

During the term January 1, 1995 through December 31, 1996, your prescription drug benefits will be administered through our pharmacy vendor. If we

receive a rebate through our vendor, we will credit you with 70% of that rebate and retain the other 30% to cover our administrative costs for the pharmacy program. This provision will not apply to your health benefit plans on and after January 1, 1997.

Your Payments

Weekly Working Capital Amount. You have agreed to pay a mutually agreed upon fixed weekly working capital amount to us for estimated health care costs. On a quarterly basis, this fixed weekly working capital amount will be reviewed and adjusted accordingly for adequacy subject to approval of both parties.

Your fixed weekly working capital amount is:

- $75,000 for the term January 1, 1995 through December 31, 1995.
- $70,100 for the term January 1, 1996 through December 31, 1996.
- $50,000 for the term January 1, 1997 through December 31, 1997
- $46,000 for the term January 1, 1998 through December 31, 1998.
- $46,000 for the term January 1, 1999 through December 31, 1999.

Weekly Electronic Credit Transactions. You will initiate an ACH credit transaction on the first four Wednesdays of each month.

At three-month intervals, we will determine if the total of your weekly credit transaction amount was enough to cover your health care costs for the preceding period. In the event the total of your weekly credit transaction amount exceeded your health care costs, we will deduct the amount of that difference, with no interest, from what you owe us for your first weekly electronic credit transaction of the following month. However, in the event your health care costs exceed the total of your weekly credit transaction amount, we will add the amount of that difference, with no interest, to your first weekly electronic credit transaction of the following month.

Monthly Charges.

Pay as Billed Payments. For the period January 1, 1995 through June 30, 1996, we will provide you with a separate monthly invoice that indicates your total administrative charges due. You must pay the total of these charges on or before the due date indicated on your monthly invoices.

Self Bill Payments. For the period beginning on or after July 1, 1996, we will provide you with a separate monthly invoice that indicates your administrative charge amount plus your member management fees or other similar fees for each contract, and through December 31, 1996, capitation fees for your Western Pennsylvania members. Then, you will calculate your enrollment for the month that we bill you and forward the total amount due us for each contract. You must pay the total of these charges on

or before the due date indicated on your monthly invoices.

We will perform a quarterly audit to verify that the total enrollment that you submit to us coincides with the total enrollment that we indicate on our records. Any difference in this enrollment must be resolved by both parties within 30 days of the audit. You must pay to us any amount due for administrative charges and member management fees and capitation amounts within 30 days after the date we notify you of the amount due.

Late or Overdue Payments

We anticipate that payments for all charges will be received by the due date. If we do not receive full payment on or before the fifteenth day after the due date, we will suspend all claim payments as of the last date through which you have paid charges to us. In addition, we reserve the right to assess a finance charge on the amount that is past due. The first time in a policy year that we do not receive payment of all charges by the due date, the finance charge will be calculated from the fifteenth day after the due date at a rate of 1.5% per month. In the event we do not receive payment of all charges by the due date later in that policy year, the finance charge will be calculated from the due date at a rate of 1.5% per month.

Any provision in this Agreement to the contrary notwithstanding, if full payment is not available within seven days after the due date, we will send

you written notice that claims will be suspended if payment is not made available within 15 days after the due date. If full payment is not available within 15 days after the due date, we will suspend your claim payments and send you a written notice that the Agreement will be terminated if full payment is not available within 30 days after the due date. If full payment is not available within 30 days after the due date, termination will be effective as of the last date through which you have paid charges to us.

If you fail to make timely payments, we will have the right of setoff against your working capital amount described above.

Acceptance

This Agreement has been executed in duplicate by the authorized representatives whose signatures appear below:

Blue Cross and Blue Shield of Massachusetts, Inc.	**Liberty Mutual Insurance Company**
/s/ Donna L. Morris	Name:/s/ Helen ER Sayles
Donna L. Morris, Director Contracts Development	
/s/ W. Patrick Hughes	Title:Sr. Vice President HR & Admin
W. Patrick Hughes, Senior Vice President Sales, Marketing and Product Management	
Dated: 8/9/99	Dated: 11/22/99

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[B-1] **B**

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(For Active Employees)

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[B-4] **B**

MEDICAL PLAN

Overview

The Liberty Mutual Medical Plan ("Medical Plan") offers eligible employees participation in a national medical plan. You can also select no coverage if you have coverage elsewhere or are a part-time employee. For purposes of this summary plan description, the following terms shall have the following meanings: "Company" means Liberty Mutual Group Inc.; "Participating Employers" means the Company and its subsidiaries that participate in the Medical Plan. A listing of Participating Employers is available in the Benefits section of the Employee Center on the Liberty Mutual Intranet.

A Self-Insured Plan

The Liberty Mutual Medical Plan is a "self-insured" plan. This means that health care claims are paid from the Company's general assets. The money used to pay the claims comes from your contributions for coverage and the Company's contributions. *Please note: The only exception is for employees who reside in Hawaii. As a result of state mandates, the benefit*

design differs and the plan option offered to Hawaii residents is a fully insured plan through Blue Cross Blue Shield of Hawaii.

Plan Design

The Medical Plan offers employees and eligible dependents a national network preferred provider option (PPO) plan with in-network and out-of-network coverage, depending on whether or not a network provider is used. Covered employees may choose to receive services from either in-network or out-of-network providers. The claims administrators for the provider networks don't provide health care insurance – they process the claims and manage the health care provider networks. Depending on the state in which you reside, your administrator is Aetna or Blue Cross Blue Shield of Massachusetts. In the states of New York and Pennsylvania, your home zip code determines whether your administrator is Aetna or Blue Cross Blue Shield. Prescription drug benefits are a component of the Medical Plan and are administered by Medco. If you live in Hawaii, your administrator is Blue Cross Blue Shield of Hawaii, and prescription drug benefits are administered by Blue Cross Blue Shield of Hawaii.

In the Aetna-administered network, preferred providers are part of the "Aetna Choice POS II" network. In the Blue Cross Blue Shield-administered network, preferred providers are part of the "Blue Care Elect Preferred Provider Organization (PPO)" network.

Under the Medical Plan there is in-network coverage and out-of-network coverage – depending on whether you choose to use a preferred provider who is in the network, or an out-of-network provider. This refers to the "network" of health care providers (including physicians, Specialists, and hospitals) that have contracted to provide quality services in a cost-effective manner. When you receive in-network care from a preferred provider, your out-of-pocket expenses are generally lower (for example, 90% or 80% coinsurance vs. 70% coinsurance).

The Medical Plan also has annual deductibles and out-of-pocket maximums. All services have [B-5] coinsurance, with the amount depending on whether you receive care from a preferred or a non-preferred provider and whether you see a Primary Care Physician or a Specialist for an office visit. The only exception is in-network Preventive Care coverage, which is covered at 100% (see page B-46). Your Base Pay determines your annual deductible and out-of-pocket maximum (see page B-21 for details).

A directory of providers who participate in each of the claims administrators' networks is available through the *myLiberty Benefits* web site, or by calling the claims administrator. Medical Plan coverage and provisions are explained in further detail in this summary plan description. The toll-free Member Services telephone number for your claims administrator can be found on your identification card, or on the *myLiberty Benefits* web site. Contact information can also be found at the end of this document.

No Coverage

You may also waive medical coverage. Unless you are a part-time employee, in order to waive coverage, as a condition of your employment, you must certify that you have coverage elsewhere at the time you make your election to waive medical coverage under the Medical Plan.

Note: All full and part-time employees who reside and/or work in the state of Massachusetts are required by state law to provide certification of coverage elsewhere if electing to waive coverage under the Medical Plan when first eligible and annually thereafter during Annual Enrollment. In the case of an election to waive coverage, if you do not submit a medical coverage waiver form to the HR Support Center within 30 days of your coverage effective date, you will "default" to Employee Only coverage in the Medical Plan. The default coverage will remain in effect unless a Medical waiver of coverage form is received by the HR Support Center within 30 days of the election date. After your waiver certification is processed, you will be reimbursed for deductions taken during the default coverage period.

General Provisions and Self-Insured Only Provisions

This summary plan description contains general information that applies to both the self-insured plan and the fully insured option in Hawaii. Pages B-4 to B-11 and B-51 to B-75 apply to both the self-insured

plan and the Hawaii option. Pages B-12 to B-51 describes the benefits of those participants enrolled in the self-insured plan.

Eligibility

You become eligible for coverage on your date of employment if you are on the U.S. payroll and are a regular full-time employee, or a regular part-time employee, scheduled and regularly working 20 hours or more per week. Individuals classified as independent contractors or leased employees are not eligible for coverage, even if they are later reclassified as common law employees for tax purposes.

Eligible Dependents

As an eligible employee, you may also choose to enroll your eligible dependents for coverage. Eligible dependents include:

- your legally married spouse; and
- your child (including any stepchild, foster child, legally adopted child or a child for whom a court order of custody or guardianship has been obtained) under age 26, unless he/she is an adult child (that is, a child age 19 and older) who is eligible for his/her own employer-based health care coverage.

* * *

[B-28] mother, discharge the mother or her newborn earlier than 48 hours (or 96 hours

as applicable). If the hospital stay is required to extend beyond the time mentioned above, the provider or member must call to get additional days authorized.

- **For all non-emergency hospitalizations**, your claims administrator must be contacted at least seven calendar days prior to admission. Your claims administrator may require earlier notification, so you should check with your claims administrator as soon as your hospitalization is scheduled.
- **For emergency hospitalizations**, your claims administrator must be contacted within 48 hours of the emergency admission.

Well-Baby Programs

The Medical Plan provides screening for risk factors in pregnancy, patient information, and case management. Contact your claims administrator as soon as your pregnancy is confirmed for additional information.

Your claims administrator then sends you educational information, sometimes accompanied by a questionnaire designed to help identify potentially high-risk circumstances. Your doctor may also be contacted to help screen for any factors that might put you at risk for complications. If further assistance is appropriate, a nurse works with you on a regular basis to help you and your doctor with any special medical needs. The program's goal is to assist women in getting the care

they need, especially in the important area of prenatal care. All information is kept strictly confidential.

Emergency Situations

In life-threatening emergency situations (e.g., severe chest pains, prolonged bleeding, broken bones, etc.) seek medical care immediately. First you pay the $100 charge for use of the emergency room, then charges for services received from a preferred or non-preferred provider are paid at 90% (80% if a Specialist) after the in-network deductible is met. The $100 charge is deducted from the total charges prior to applying the applicable deductible and/or coinsurance and does not apply to the annual deductible or out-of-pocket maximum. The $100 charge is waived if you are admitted.

Definitions

A masculine personal pronoun includes the feminine where the context requires.

"Accidental injury" or **"injury"** means bodily injury caused by an accident. This includes related conditions and recurrent symptoms of such injury.

"Active employee" means an employee of a Participating Employer who works regularly. The employee may work at any of the Participating Employer's business locations. He may also work at any other location where the Participating Employer's business requires him to travel.

"Ambulatory surgical center" (or freestanding emergency center) means a facility that:

(a) is established, equipped and operated mainly to perform surgical procedures;

(b) is operated under the supervision of a staff of physicians and provides the full-time services of at least one RN;

(c) is licensed by the jurisdiction in which it is located;

* * *

[B-46] **Personalized Medicine Program**

The Program, which is voluntary, centers on advances in personalized medicine (pharmacogenomics) and offers the opportunity to use genetic testing to determine the appropriate dosage or effectiveness of a specific drug. By determining which drugs and dosages will work best for an individual, medication therapy can be safer and more effective. Currently, the Program focuses on improving therapies for warfarin (sold under the brand name Coumadin), tamoxifen, Plavix® and medications that treat certain types of cancer as well as HIV/AIDS.

Services for the Program may include:

- Identifying retail and mail pharmacy claims for warfarin or tamoxifen
- Contacting the physician first for approval to contact a patient to discuss availability of testing

- Contacting patient to discuss the program and to obtain knowing and voluntary consent
- Providing test kit to patients
- Processing the test and providing results to the physician and the Medco pharmacist
- Contacting the physician to discuss test results

The completely voluntary and confidential test, offered to you at no cost, allows you and your physician to determine whether any changes in your drug therapy may be beneficial.

Preventive Care

Benefits for Children through Age 18

A baby is covered as a dependent from the date of birth, provided that dependent coverage is in force at that time, or is added, as a Status Change, within 60 days of the birth. This includes coverage for hospital charges for routine nursery care during the mother's hospital confinement, physician's charges for circumcision, and the initial in-hospital physician's visit.

Benefits are provided for in-network outpatient preventive care services from the date of birth through 18 years of age, including physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening and assessment at the following intervals:

- six times during the child's first year after birth,

- three times during the next year,
- annually thereafter, through age 18. (Note: Out-of-network care is limited up to age 6)

These services shall also include hereditary and metabolic screening at birth, appropriate immunizations (only when an in-network provider is used) and tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the physician. The services are covered at 100% without an annual deductible if a preferred provider is used. If an out-of-network provider is used, the out-of-network benefits level applies. All other applicable provisions, limitations, exclusions and exceptions of the Medical Plan also apply.

Coverage For Health Examinations (Age 19 and Older)

Under the in-network level of benefits, members may receive an annual health assessment from an in-network (or preferred) provider, limited to one visit per calendar year, with services covered at 100% without an annual deductible. Routine immunizations, tests, and lab fees administered as preventive services during the health assessment are included.

Annual Flu Prevention

Under the in-network preventive services benefits, members may receive an annual flu shot from an

Vermont Frequently Asked Questions (FAQs) for the Collection of Commercial Claims Data

1. *Vermont has an October 31, 2008 due date for historical production files for monthly and quarterly submitters. What is the timeline for deliverables and testing between now and then?*
2. *Is there a plan to allow for technical questions in the future?*
3. *What is the timeline and content of the statistical plan?*
4. *Are denied claims required to be submitted?*
5. *How should prescription drug services rendered within a medical claim be represented?*
6. *What is my submitter code?*
7. *Is there a method to submit late claims paid during a prior submission period?*
8. *How do I determine what data should be included in a monthly claims file?*
9. *Should vision claims be included?*
10. *What lines of business are to be included?*
11. *Why do some of the coded values differ across file types? Why do some code values not have a value to represent unknown?*
12. *What provisions are in place to ensure data confidentiality, particularly with regard to sensitive diagnosis (HIV/AIDS) and procedures (abortion)?*
13. *If certain fields are unavailable when we submit data, but later become available will we need to resubmit everything?*

14. *Our membership eligibility data is based on a start and end month. Can we report it to the MHDPC in that manner?*

15. *If the coverage level code of a member changes during the month, which coverage level code do you want – the first, the last or all of them in a given month?*

16. *Our internal coded values differ from the regulation and do not directly map, what do we do?*

17. *Do we include a member identifier in the plan specific contract number field (ME009, MC008, PC008)?*

18. *We cannot break our provider name information into separate fields, is this acceptable?*

19. *In our system we do not use a version number to identify adjustments. What do we do?*

20. *How should we report multiple E-Codes on a claim?*

21. *How should we report multiple revenue codes or procedure codes listed on a single claim line?*

22. *Should text fields be padded with blanks and should numeric fields be padded with zeros to their maximum length?*

23. *We sell products across state borders in New England and therefore have members that may have changed state residence over time. We only keep the latest subscriber address for a given subscriber and their dependents. Therefore, if a member living in New Hampshire in November 2007 moves to Vermont in December 2007 and we pay claims for that member in December 2007*

with an incurred date in November 2007 or prior what do we do with these claims?

24. *What is meant by the Insured Group or Policy Number (ME006, MC006, PC006)?*
25. *What about payer-specific provider specialty codes, procedure codes, and diagnosis codes?*
26. *How do the Data Load and Data Quality Edit thresholds work?*
27. *Are we to include the procedure code (MC055) as it was submitted or as it was paid?*
28. *In the pharmacy file layout you are asking for the charge amount. Our system does not have that value. What should we do?*
29. *Are there ways to determine if our transmission is as safe as possible? What are the details?*
30. *What is the transmission time frame for the data?*
31. *Whom do I contact if I am having upload problems?*
32. *Do we have to use the asterisk (*) as the field separator in the files? What if a text value contains an (*) within it?*
33. *There is something wrong with the encryption software. I can't get it to work. What should I do?*
34. *How are Type of Bill – MC036 and Site of Service – MC037 related?*
35. *How will I find out if my submission failed?*
36. *Will MHDPC be signing confidentiality agreements with the individual plans and data submitters?*

37. *What are the most common mistakes made when submitting data?*

38. *For the Facility Type field (MC037), we cannot distinguish ambulance land (41) from ambulance – air or water (42). How should we code our ambulance claims?*

39. *How are new codes authorized by CMS but not included in the regulation to be reported?*

40. *Should students be reported in the eligibility and claims data?*

41. *How do we report a student in the Individual Relationship Code (ME012, MC011, PC011) field?*

42. *How do we report a disabled dependent in the eligibility field Individual Relationship Code (ME012)?*

43. *What is the relationship between medical claims fields Type of Bill (MC036) and Facility Type (MC037)?*

44. *For the medical claims field Facility Type, we cannot distinguish Residential Substance Abuse Treatment Facility (55) from Psychiatric Residential Treatment Center (56). How should we handle this?*

45. *Is it acceptable to have different versions of the city name (ME015, MC014, MC033, PC014, PC022) such as East Royalton, E Royalton for the same zip code (ME017, MC016, MC035, PC016, PC024)?*

46. *We do not collect country (MC072) for our providers. How should we report this?*

47. *We pay a lot of case rate and/or global rates on certain types of claims, how are they to be reported?*

48. *I was just notified that my file failed, how long do I have to address the issues?*

49. *Is Medicare Part C and D required in this data collection?*

50. *If a member is terminated on the second day of the month and has no claims, should s/he still be included?*

51. *For diagnosis code fields, we have values like V73.88. Are they expecting V73 or V74 or V7388 in the extract file?*

52. *Should the eligibility records of non-Vermont residents who received covered services provided by Vermont health care providers or facilities be included or excluded? If non-Vermont residents are to be included, which month's eligibility records would be expected – the eligibility for the same month as the paid claims?*

53. *My understanding is that the insurance carrier is responsible to provide the data that we provide to them, therefore, we (the Third Party Administrator) do not report directly to you.*

54. *The header record for each file contains a comments field, HD008. Can this field be left empty?*

55. *Please confirm it is okay to put '0' (which translates to N/A) in the ME031 Special Coverage field as we are not familiar with the other values listed.*

1. **Vermont has an October 31, 2008 due date for historical production files for monthly and quarterly submitters. What is the timeline for deliverables and testing between now and then?**
   Since the contract signing in early2008, MHDPC has been working on the necessary updates to the system to accommodate testing of carrier files. The system will be available to receive test data on October 14, 2008. The detailed timeline for testing and submission of the historical data is part of the statistical plan and includes the registration of carriers, assignment of carrier IDs and notification back to the carriers, carrier level encryption testing and necessary receipt of certain coded data element definitions (i.e., provider specialty codes and if necessary "Home Grown" or local procedure or diagnosis codes).

2. **Is there a plan to allow for technical questions in the future?**
   MHDPC staff is available to answer questions via email, conference call or face-to-face meeting. At any point a carrier can contact MHDPC with technical and/or compliance questions by sending an email to VTinfo@ncdms.org A MHDPC staff member will respond and arrange for the appropriate follow up. In addition to one-on-one communication, a quarterly newsletter will be created to inform all carriers of general technical and compliance status and other topics of interest. Newsletters will be distributed via email and posted on the web site.

3. **What is the timeline and content of the statistical plan?**
The statistical plan as approved by the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) will be released to all identified carriers and interested parties and posted on the web site. The statistical plan includes:
Data encryption description;
System start up time line;
Data collection regulation;
Data submission instructions including submission time line and submission formats;
Instructions for testing data and submitting historical data; and
Data quality standards including data element loading and data quality editing thresholds.

4. **Are denied claims required to be submitted?**
In general denied claims are not to be submitted in any of the claims extracts. However, there are issues that complicate this general regulation. There are primarily two types of denied claims:

a. Where the entire encounter with a provider is denied (e.g., the encounter before or after a member's coverage period, the service was not a covered benefit under the member's benefit structure)

b. Some but not all of the service lines are not covered within a claim (e.g., the service line for a surgical tray is denied because it is included as part of the payments made for the surgery procedure line itself). In the

examples above, the claims for encounters that are totally denied will be excluded and claims with mixed covered and non-covered services will include only the service lines for the covered services.

If a carrier processes global claims (e.g., a particular surgery for a hospital is paid under a global fee regardless of the member's complications and/or length of stay resulting in only the first line of the claim containing any paid dollars and all other detail service lines are "denied"), all of the claim lines in the global claim should be submitted to the MHDPC.

If a carrier has no responsibility/liability for a service that was rendered under the member's benefit structure then the claim/claim lines should be excluded. If the carrier has responsibility to cover a particular rendered service, but some covered services appear to be denied because of processing and payment structures in place then those claims/claim lines should be included in the extract.

5. **How should prescription drug services rendered within a medical claim be represented?**

Any prescription drug services that are rendered as part of the medical claim should be included in the medical claim file and be represented using an appropriate revenue code (MC054) and/or J-code reported in the CPT field (MC055). It is understood that for prescription drug claims identified through a revenue code will not have an associated NDC code to indicate the specific

drug dispensed. Also, it is understood that these claims/claim lines will not be present in the prescription drug claims.

6. **What is my submitter code?**
The MHDPC submitter codes, also known as the payer code, payer ID, carrier ID, etc., will be assigned and sent to you once your organization has registered with the MHDPC. For BISHCA the format of a submitter code will be a 7 or 8 character value with the first two characters being 'VT' – state code, the third character is a value of either 'C' or 'T' or 'G' where C represents a commercial insurer, T represents a TPA and G represents a government payer like Medicaid or Medicare. The next four characters will be an assigned number with the 8th position reserved for a suffix to distinguish reporting systems within a carrier.

7. **Is there a method to submit late claims paid during a prior submission period?**
Yes there is; however, the MHDPC wants to limit these types of submissions to a minimum as it complicates transferring data to the State. Basically, if a carrier identifies to the MHDPC a block of data that should have been included in a monthly paid data submission that has already been accepted by the MHDPC but for one reason or another it was omitted, then the MHDPC will issue a temporary submitter code with a new suffix to that carrier. The carrier will use this temporary code to submit the previously paid data and the MHDPC has a process in place that once this special data submission has been accepted the data will be migrated to the proper submitter

code. If a carrier's original submitted file has yet to be accepted by the MHDPC then the carrier will be requested to re-submit both the data from the original data submission and any new data identified in one file. Also please read the FAQ on how do I determine what should be included.

8. **How do I determine what data should be included in a monthly claims file?**
The monthly submission of claims data from a carrier to the MHDPC is termed a "Paid Claims Dataset". To verify that the data is [sic] a submission is being accurately selected the MHDPC uses the Header record begin and end dates formatted as YYYYMM and in each detail record we use fields – Medical MC017 & Pharmacy PC017 – Date Service Approved (AP Date). The MHDPC verifies that each date supplied in fields MC017 and PC017 are between the header records begin and end date timeframe. For a single month submission the header record would contain the same value in both begin and end date fields. Now, what data field should be used to populate fields MC017 and PC017? There are a number of potential values that could be used to populate these fields, but whatever value is used needs to be consistent within a carrier from month to month, otherwise we run into problems with either missing claims for a certain time period or receiving duplicate claims for a certain time period. As a basic regulation the date field that should be used to populate these two data elements is the date field that is used by the carriers extract program to determine what data should be included in a given months data submission. That means that is the true paid date is

used to select records for inclusion in a file than the paid date values should be placed in these fields, but if a data warehouse update/load date is used to select records for a data submission then that date value should be used to update these data elements. We have found through working with carriers submitting data for Maine and New Hampshire that any of the following fields could be employed for selection and inclusion of data: Claim Paid Date, Claim Accounts Payable Date, Check Cut Date or Warehouse Update/Load Date, but in any case once a method has been selected by a carrier we do not want the carrier to later change the value that they are using.

9. **Should vision claims be included?**
If the vision service is a covered medical benefit (e.g., the member over 18 who can receive one eye exam at a participating eye care specialist once every two years) it must be submitted as a medical claim. Unless it is a covered medical benefit, MHDPC should not receive any claims for eye care products, such as prescription eyeglasses, contacts, solution, etc. Any prescriptions covered under a member's prescription drug benefit would be included in the pharmacy claim submission.

10. **What lines of health insurance business are included and excluded?**
Please refer to Vermont *Regulation H-2008-01*, Sections 4 and 5 to identify the lines of health insurance included in the claims reporting mandate and also what is excluded.

11. **Why do some of the coded values differ across file types? Why do some code values not have a value to represent unknown?**
Although the HIPAA standard coding schema was adopted for the coding structure within the Vermont claims regulation, the HIPAA electronic transmission coding standards are not standard across the different file types. Therefore, the prescription drug specifications call for gender codes of 1, 2 or 3 while the medical and eligibility specifications require a gender code of M, F or U. This follows the HIPAA requirements for these data sets. Please use caution when setting up your extract to code all of these fields appropriately. Similarly, if a coded field does not have a value to indicate "unknown" it is because HIPAA did not allow for an unknown value to be reported. In a few instances only a subset of the HIPAA codes are allowed in the extract. This was done to restrict the use of non-specific codes.

12. **What provisions are in place to ensure data confidentiality and protection of potentially sensitive information?**
Through the use of the encryption software all direct PHI data elements are encrypted through a one-way hashing function before they leave the carrier so the VHCURES files do not contain direct patient or member identifiers. Under Vermont regulation H-2008-01, provisions addressing the release and use of VHCURES data are found in Section 8 in: http://www.bishca.state.vt.us/HcaDiv/RegsBulls/hcaregs/REG_H-2008-01.pdf

13. **If certain fields are unavailable when we submit data, but later become available will we need to resubmit everything?**
The data layouts currently accommodate all known required data elements. A carrier must provide all required data elements appropriate for the data set and the time period at the time of submission. Completeness thresholds have been established for each data element and are documented in the statistical plan. Submissions with data elements failing the completeness threshold for one or more fields will be rejected in their entirety. A carrier unable to meet the completeness. A carrier unable to meet the completeness threshold due to restrictions within their system will be referred to BISHCA for a decision on how to proceed.

14. **Our membership eligibility data is based on a start and end month. Can we report it to the MHDPC in that manner?**
No. The eligibility data is submitted in a monthly format with one record for each covered life eligible for one or more days of services during the reported month. Each eligibility record in a given month's file will represent one active member with all reported data elements representing either the status as of the end of the reporting month or as of the premium billing date. For the required historical data feeds carriers will submit one record per member per month of active coverage during the 15 month period. For the historical data, MHDPC is requiring that each month of eligibility data be submitted in a separate monthly file.

15. **If the coverage level code of a member changes during the month, which coverage level code do you want – the first, the last or all of them in a given month?**
The status code for the coverage level field in the eligibility file should be as of the end of the month or the applicable code for when the premiums were billed for that member during the month. This same regulation applies for all the other data elements in the membership file, such as the employer group/policy number, member zip code, etc. In all cases, only one value should be reported in a membership record and only one membership record should exist for a member each month.

16. **Our internal coded values differ from the regulation and do not directly map, what do we do?**
Any internal carrier coded values that do not directly map to coded data element values within the regulation will need to be evaluated on a field-by-field basis. Please email us at VTinfo@ncdms.org and list the regulation data element field number in question as well as the values and descriptions that you have available to map. We will work with you to assign the values as accurately as possible.

17. **Do we include a member identifier in the plan specific contract number field (ME009, MC008, PC008)?**
No. It is common for a carrier to have a member identifier or sequence number attached to the end of the subscriber contract number sometimes separated with an asterisk (*) or other value. The

combination of these two values represents the member's full identification number. In this situation, the regulation calls for you to submit the plan specific contract number that would be used to identify all members of a family (subscriber and dependents). The sequence number should be placed in the member sequence number field (ME010, MC009, PC009) and the asterisk or other delimiter is ignored.

18. **We cannot break our provider name information into separate fields, is this acceptable?**
When the provider name CANNOT be separated into first name, last name, middle name and suffix data elements, then the entire provider name should appear in the "Service Provider Last Name/Organization Name" field. This should only be done as a last resort.

19. **In our system we do not use a version number to identify adjustments. What do we do?**
If a carrier's processing system or data warehouse does not use a record versioning method to identify adjustment records for a claim, then the version number field should be defaulted to a value of 0. This will be acceptable as long as any reversal and/or adjustment records are reported in such a way that a given claim line can have all of its versions identified and consolidated together so that the result is one claim line for an incurred service processed over a given paid date range with the correctly summarized dollar values. As part of the follow up to the carrier registration, we will be asking the carrier to explain in English terms and examples how BISHCA would

take the carrier's submitted paid dataset and convert the claim lines into an incurred dataset for a given paid date range resulting in correctly summarized dollars. This information will be passed on to BISHCA.

20. How should we report multiple E-Codes on a claim?

If a given claim contains multiple E-Code values in the diagnosis fields then the first E-Code encountered in the processing of the claim should be loaded into the E-Code data field (MC040) in the extract submission. All other E-Codes in other diagnosis fields should be listed in the Other Diagnosis code fields (MC042-MC053) after all other regular ICD-9 diagnosis codes have been listed. An E-Code should never be listed in the primary diagnosis data field (MC041).

21. How should we report multiple revenue codes or procedure codes listed on a single claim line?

The MHDPC is acquiring examples of how this can happen. We do understand that on a hospital/facility claim a given claim line may have both a revenue code and a Procedure/CPT code. In that instance the revenue code is reported in MC054 and the CPT code is reported in MC055. It is unclear how a single claim line can have multiple CPT codes or multiple revenue center codes assigned to it unless one code is the original billed code and one is the modified payment code based on contracting changes made by the carrier. If the later is true MHDPC staff will work with you to arrive at a solution.

22. **Should text fields be padded with blanks and should numeric fields be padded with zeros to their maximum length?**
No padding should occur. Although the record layouts list a maximum length that will be accepted, the submission is designed to be variable length. No text field should be blank or space padded on either the right or left and the numeric fields should not be zero padded to the left of a value. If this is done, it can cause your transfer rate to slow down. Even though the file to be transmitted is compressed, there is still space used to represent the blanks, spaces and zeros and, in a large data file, this additional space could be substantial enough to lengthen the transfer time. Also, if the fields to be encrypted have been blank/space padded then the encryption routine may fail (if the whole field is blank) or may not properly encrypt the value.

23. **We sell products across state borders in New England and therefore have members that may have changed state residence over time. We only keep the latest subscriber address for a given subscriber and their dependents. Therefore, if a member living in New Hampshire in November 2007 moves to Vermont in December 2007 and we pay claims for that member in December 2007 with an incurred date in November 2007 or prior what do we do with these claims?**
We recognize that this issue exists. We would want to see those claims submitted rather than put the burden of eliminating those claims from the file on a carrier. This policy will result in claims records with no supporting eligibility

records in our database for November 2007 We will evaluate the prevalence of claims unsupported by eligibility data on an ongoing basis and determine if they should be dropped from the database at a later date. The MHDPC feels this is the best current solution rather than ask you, the carrier, to try and determine if and when the address of a subscriber changed from one state to another.

24. What is meant by the Insured Group or Policy Number (ME006, MC006, PC006)?

The Insured Group and/or Policy Number is the employer group or account number(s) for the contracted employer. There may be one or more of these numbers for a given employer group according to how your system is set up. Furthermore, if your plan writes individual policies, this number would be the actual policy number unless your system uses the subscriber's identification/contract number for an individual policy number. In that situation, the individual's insured group or policy number should be reported as "INDIVIDUAL".

25. What about payer-specific provider specialty codes, procedure codes, and diagnosis codes?

There is a provision in the regulation to have all carriers submit a spreadsheet of all carrier assigned provider specialty codes with their descriptions. The spreadsheet should contain the provider specialty code and a definition of the code. MHDPC also requires a spreadsheet that contains any home grown or local procedure or diagnosis codes with their corresponding descriptions.

Failure to provide the local codes could cause your medical claims submissions to fail for the inclusion of procedure and diagnosis codes that are not recognized by the system.

26. How do the Data Load and Data Quality Edit thresholds work?

Based upon the review of existing claims databases, standards have been established for the quality of the data to be submitted. In the data load, each data element has been assigned a minimum percent completeness threshold. In general the data element's completeness is evaluated by the total number of valid entries divided by the total number of records submitted. However, for some data elements, the denominator is a subset of the data because of the nature of the data element. The specifications for calculating each data element's threshold and the statewide number for that data element are documented in the statistical plan. Failure of a submission to meet one or more of the completeness thresholds will result in the automatic failure of the submission.

Similarly, the data quality edits are designed to evaluate the content of the data submitted and frequently involves the comparison of two or more data elements. The data quality thresholds represent the maximum tolerance for data issues. The data quality specifications and the tolerance thresholds are documented in the statistical plan. Failure of a submission to stay below one or more of the data quality edits will result in the failure of the submission.

It is understood that system restrictions may prevent a carrier from meeting all of the data tests. In those situations, MHDPC will work with the carrier to document the source of the problems to present to BISHCA for a temporary or permanent exemption. All such deviations from the statewide quality standards must be approved by BISHCA. .

27. **Are we to include the procedure code (MC055) as it was submitted or as it was paid?**
If you have the ability to re-code CPTs based on claims processing and standard CPT coding logic, then the CPT included in the file should be the CPT tied to the actual payment dollar amount.
Medical file example:
MC055 – CPT Code of procedure as paid
MC062 – $ amount of submitted procedure (billed charges)
MC063 – $ amount of paid procedure

In this example the CPT codes for the dollar amounts listed in MC062 and MC063 could be different and the actual CPT code that is submitted would be the one tied to the dollar amount listed in MC063.

28. **In the pharmacy file layout you are asking for the charge amount. Our system does not have that value. What should we do?**
The amount/value of this data element should represent the fully loaded cost/charge of the pharmaceutical dispensed. It should contain at least the Ingredient Cost/Billed Amount (PC037),

the Dispensing Fee (PC039), any administrative fee and any applicable tax.

29. **There are two things that you can do to make the transfer as secure as possible:**

    a. Use the SSL certificate to insure that the web site you are connecting to is, in act, the web site that you are supposed to be connecting to. When connecting to the secure portion of the NCDMS web site (user services including encryption utility software download, data file upload, and data submission reports), you should see an icon of a locked golden padlock along the bottom of your browser window. By clicking on this icon, the certificate can be viewed. You should examine the certificate and make sure that the certified network address, organization name, and organization location are what they should be (secure.mhic.org, Maine Health Information Center Inc, Manchester, Maine, US) and that the certificate date range is valid. If this information is not valid, or if you see the icon of an unlocked golden padlock along the bottom of your browser window, you should contact us before proceeding.

    b. Use the highest supported level of encryption when transmitting data to us. There are two levels of encryption that are supported by the SSL standard (50-bit and 128-bit). Some web browsers support only the lower level of encryption (50-bit). Our web server supports higher level 128-bit encryption but will negotiate with the web browser that is asking for

a connection and will drop down to the lower level 50-bit encryption if that is all that your browser can support. The 128-bit encryption is significantly harder to crack than the 50-bit and if you are concerned about security, you should make sure that the browser you are using supports 128-bit encryption. You can check this by clicking on the help option in Internet Explorer and going to the "about Internet Explorer" drop-down menu option. On the pop-up screen, there will be an entry titled "cipher strength" which will say either 50-bit or 128-bit. If your browser is using 50-bit encryption, you can download the 128-bit version of Internet Explorer at no cost from Microsoft.

30. **What is the transmission time frame for the data?** In general, data must be filed by the last day of the month for the previous month's activity. Therefore, on April 30, 2009, data for March 2009 must be submitted. Mandated reporters with 2,000 or more covered Vermont lives must submit monthly and begin submitting in October 2008 for the period of January 2007 thru September 2008. Mandated reporters with 500-1,999 covered Vermont lives will start submitting data in October 2008 for the period of January 2007 thru September 2008 and assume a quarterly submission schedule after the historical data is in. Mandated reporters with 200-499 covered Vermont lives will begin submitting in October 2008 for the period of January 2007 thru December 2007 and assume an annual submission schedule after the historical data is in.

31. **Whom do I contact if I am having upload problems?**
    For general transmission, technical or data questions or for web upload questions please contact VTinfo@ncdms.org and your question will be routed to an appropriate staff member for a response.

32. **Do we have to use the asterisk (*) as the field separator in the files? What if a text value contains an (*) within it?**
    The use of the asterisk (*) as the field separator is a HIPAA standard and a regulation specification requirement and MUST be used to separate each field within the required files. Although, not specifically stated in the regulation, it is perfectly valid to enclose any or all text/alpha fields within double quotes – ex: "abc". If a text value that is required actually contains an (*) as one of the characters then that field MUST have double quotes around the entire value – ex: "ab*cd". It is not acceptable to have a double quote embedded in any text value. If double quotes exist in your incoming data (generally found in Drug Name (PC027)) they must be removed prior to submission of the data.

33. **There is something wrong with the encryption software. I can't get it to work. What should I do?**
    a. Download the sample data files from the web site and run those through the encryption software. If this does not work, email us at VTinfo@ncdms.org

b. Check your data for imbedded asterisks in the data values. These must be enclosed in double quotes.

c. If the above do not correct the problem, email us at VTinfo@ncdms.org.

34. How are Type of Bill – MC036 and Facility Type – MC037 related?

These two data elements are mutually exclusive. Type of Bill (MC036) should only be available for hospital/facility claims (claims from the UB 92/04 forms or 837 HIPAA facility transaction set) and facility type (MC037) should only be available for professional claims (claims from the HCFA-1500 forms or 837 HIPAA Professional Transaction set). NCDMS looks for the combination of these two fields to be filled in 100% of the time and are critical data elements for the system's determination of denominator values to perform Load and DQ edit threshold checks.

35. How will I find out if my submission failed?

All registered contacts for a carrier will receive emails from NCDMS for submissions automatically failed by the system. The email will briefly explain the reason for the failure. The details of problems associated with the data can be viewed by logging on to the system and looking at the system entries associated with that submission. Emails may also be sent by MHDPC staff to the contacts for data quality issues. These emails are customized and contain specific information about the problems identified. An email initiated by MHDPC staff often results in opening a dialogue between the carrier and the MHDPC staff.

36. Will MHDPC be signing confidentiality agreements with the individual plans and data submitters?

MHDPC will not be signing agreements with the individual submitters. The Department of Banking, Insurance, Securities and Health Care Administration of Vermont has the statutory authority to compel the collection of this data and will serve as the agency responsible for safeguarding its contents and use. Since MHDPC is functioning as an agent of BISHCA, no signed agreements are required.

37. What are the most common mistakes made when submitting data?

Any of the following can cause the submission to be rejected.

a. **Wrong relationship code (ME012, MC011, PC011).** HIPAA standards call for different code values for eligibility data vs. claims data. For example, the employee is coded as 20 in MC011 and as 18 in ME012.

b. **Wrong product code (ME003, MC003, PC003).** HIPAA standards call for different code values for eligibility data vs. claims data. For example, indemnity insurance is coded as IN in ME003 and as 15 in MC003.

c. **Low paid to charge ratio in claims data (MC063 : MC062).** This is generally because the payer has failed to code the product as Medicare (MC003 = MA, MB) or failed to code the claim status as secondary (MC038 = 02).

d. **Claims unsupported by eligibility data.** In general over 95% of the claims incurred for a given month should be supported by eligibility data submitted for that same month. This does not happen when the member identifiers are not reported exactly the same way in the eligibility file and in the claims file.

e. **Invalid and missing procedure codes.** If a payer accepts local CPT codes and does not provide those codes and their associated descriptions to the MHDPC, records with those local codes will be flagged as in error. If the payer makes payments directly to members and there is no procedure code information, a dummy code must be entered in the CPT Field (MC055). We recommend a code of MBR. If the plan pays for prescription drugs through the medical plan and no NDC code or J-Code or revenue code is available, a dummy code must be entered in the CPT Field (MC055). We recommend a code of DRUGS. If you use codes other than those recommended, you must report those to us.

f. **Invalid diagnosis codes.** Payers must report all valid characters of the ICD-9 diagnosis code. Some payers collect only the first 3 characters. This will cause the submission to fail. Decimal points must not be included in the reported diagnosis code.

g. **Too many members associated with a single contract.** This is generally an eligibility file problem caused by reporting the group or policy number in the contract field

(ME009). When populated, ME009 should be unique for the subscriber. This field must not be submitted with all 9's, 0's, etc. If the subscriber's social security number is provided, this field can be blank.

h. **Average age over 65.** It is highly suspicious to see a submission with an average age over 65 and the product code not set to Medicare. Such a submission will fail until corroborated or corrected by the carrier.

i. **Missing provider information.** Provider information is required for all medical claims. If payments are made to the member, an entry still must be made in the provider last name field (MC030), the provider specialty field (MC032) and in the service provider number field (MC024). All records must have a service provider number, service provider name and a service provider tax ID. Failure to provide this information will cause the submission to fail.

j. **Mixed signs in a single record.** Positive dollar amounts are not to be preceded by a + sign. We expect all adjustment records with negative dollars amounts will have all dollar fields as well as the quantity or unit fields coded as negative. If your system adjudicates claims in such a way that a line item may have both negative and positive records, you will need to explain this to us or the submission may fail.

k. **Dates out of range.** The HDR and TRL records specify the earliest and latest dates

submitted in the file. For eligibility data this relates to year and month (ME004, ME005), for medical claims date service approved (MC017) and for pharmacy claims date service approved (PC017). A submission with one or more records outside the date range on the HDR and TRL records will be rejected.

l. **Invalid file format.** A file submitted with the wrong number of data elements (too few or too many) for the data type will be rejected. A file submitted with alpha data in a numeric field will be rejected.

38. For the Facility Type field (MC037), we cannot distinguish ambulance land (41) from ambulance – air or water (42). How should we code our ambulance claims?
Code them as ambulance – land (41)

39. How are new codes authorized by CMS but not included in the regulation to be reported?
Any valid CMS codes may be reported for a data field. Please contact vtdata@ncdms.org with new values you intend to use before submitting the data. This will allow us to add the values to our reference tables to prevent your submission from failing.

40. Should students be reported in the eligibility and claims data?
Yes, if they are permanent residents of Vermont or they have had services provided by a Vermont provider.

41. **How do we report a student in the Individual Relationship Code (ME012, MC011, PC011) field?**
Students should be coded as 19 – Child. We recognize that students can be as old as 26.

42. **How do we report a disabled dependent in the eligibility field Individual Relationship Code (ME012)?**
If the dependent is < 18, code the member as 19 – Child. If the dependent is > 18, code the member as 34 – Other Adult.

43. **What is the relationship between medical claims fields Type of Bill (MC036) and Facility Type (MC037)?**
These fields are not mutually exclusive. Type of Bill (MC036) should only be populated on UB facility claims and Facility Type (MC037) must be populated on professional claims. Facility Type (MC037) may also be reported for facility claims.

44. **For the medical claims field Facility Type, we cannot distinguish Residential Substance Abuse Treatment Facility (55) from Psychiatric Residential Treatment Center (56). How should we handle this?**
Use the diagnosis codes to distinguish between the two codes. If a patient has both a substance abuse diagnosis and a psychiatric abuse diagnosis on the claim, code the claim according to whichever of those appears first.

45. **Is it acceptable to have different versions of the city name (ME015, MC014, MC033, PC014, PC022) such as East Boston, E Boston for the same zip code (ME017, MC016, MC034, PC016, PC024)?**
Yes, that is allowed.

46. **We do not collect country (MC072) for our providers. How should we report this?**
If the provider's zip code field (MC035) contains a valid US zip code, enter US in the country (MC070) field.

47. **We pay a lot of case rate and/or global rates on certain types of claims, how are they to be reported?**
Many carriers have reported case rate or global claims with the total paid amount for the claim being reported on only one line of the claim with a claim status = 1 (paid as Primary) and all other detail claim lines are listed with an associated charge amount and no paid amount. The subsequent detail claim lines are usually listed with a claim status = 4 (denied service line). We understand that this is a function of your claims processing system. However, from a research and reporting perspective, all services rendered under this type of provider agreement are considered covered services. Therefore, it would be preferable to have all detail claim lines reported with the same claim status value as the claim line that actually contains the payment information.

48. I was just notified that my file failed, how long do I have to address the issues?

As stated in the regulation, you will have 10 business days from the time of notification that a file has failed at some point in the process. This ten-day window is a one-time period to address the identified issues in one of the following manners:

a. The identified issue is corrected and a new updated data file is submitted that shows the issue as resolved or;

b. The MHDPC and/or BISHCA staff have been contacted and an approved action plan with specific dates has been identified to resolve the outstanding issue/s. If the identified issue is corroded and new problems are introduced, the original 10 day time period is retained as the correction period. If, at the end of 10 business days, the data issue(s) have not been resolved and/or an approved action plan is not in place, the issue will be turned over to the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) for possible action.

49. Is Medicare Part C and D required in this data collection?

Yes, Medicare Part C and D members and claims are required in this data collection.

50. If a member is terminated on the second day of the month and has no claims, should s/he still be included?

Yes, all members should be reported regardless of the length of membership in the given month.

51. For diagnosis code fields, we have values like V73.88. Are they expecting V73 or V74 or V7388 in the extract file?

For diagnosis codes we would expect "V7388" for the V73.88 code.

52. Should the eligibility records of non-Vermont residents who received covered services provided by Vermont health care providers or facilities be included or excluded? If non-Vermont residents are to be included, which month's eligibility records would be expected – the eligibility for the same month as the paid claims?

Eligibility records should be included for non-Vermont residents for the month the service was provided.

53. My understanding is that the insurance carrier is responsible to provide the data that we provide to them, therefore, we (the Third Party Administrator) do not report directly to you.

Please refer to *Regulation H-2008-01* for the definition of health insurer and for entities included and excluded in the reporting mandate as described in Sections 4 and 5. The Vermont state regulation specifies that TPAs are health insurers and if they possess claims data, eligibility data, provider files and other information relating

to health care provided to Vermont residents or by Vermont health care providers and facilities they shall submit claims data if the total number of Vermont resident members served is greater than 200 or 200 non-resident members received covered services provided by Vermont providers or facilities.

54. The header record for each file contains a comments field, HD008. Can this field be left empty?

Yes, field HD008 – comment field may be left blank.

55. Please confirm it is okay to put '0' (which translates to N/A) in the ME031 Special Coverage field as we are not familiar with the other values listed.

Yes, "0" is the value you need to enter if not applicable to your company.

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H-2008-01: Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES)

Appendix B-1: Header Record Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
HD001	Record Type	1/31/2007	Text	2	HD
HD002	Payer	1/31/2007	Text	8	Payer submitting payments BISHCA Submitter Code
HD003	National Plan ID	1/31/2007	Text	30	CMS National Plan ID
HD004	Type of File	1/31/2007	Text	2	DC Dental Claims ME Member Eligibility MC Medical Claims PC Pharmacy Claims
HD005	Period Beginning Date	1/31/2007	Integer	6	CCYYMM Beginning of paid period for Claims Beginning of month covered for Eligibility
HD006	Period Ending Date	1/31/2007	Integer	6	CCYYMM End of paid period for Claims End of month covered for Eligibility
HD007	Record Count	1/31/2007	Integer	10	Total number of records submitted in this file Exclude header and trailer record in count
HD008	Comments	1/31/2007	Text	80	Submitter may use to document this submission by assigning a filename, system source, etc.

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Appendix B-2: Trailer Record Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
TR001	Record Type	1/31/2007	Text	2	TR
TR002	Payer	1/31/2007	Text	8	Payer submitting payments BISHCA Submitter Code
TR003	National Plan ID	1/31/2007	Text	30	CMS National Plan ID
TR004	Type of File	1/31/2007	Text	2	DC Dental Claims ME Member Eligibility MC Medical Claims PC Pharmacy Claims
TR005	Period Beginning Date	1/31/2007	Integer	6	CCYYMM Beginning of paid period for Claims Beginning of month covered for Eligibility
TR006	Period Ending Date	1/31/2007	Integer	6	CCYYMM End of paid period for Claims End of month covered for Eligibility
TR007	Date Processed	1/31/2007	Date	8	CCYYMMDD Date file was created

H-2008-01: Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES)

Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME001	Payer	1/31/2007	Text	8	Payer submitting payments BISHCA Submitter Code
ME002	National Plan ID	1/31/2007	Text	30	CMS National Plan ID
ME003	Insurance Type Code/Product	1/31/2007	Text	2	12 Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Heal Plan 13 Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month coordination period with an employer's group healtl plan 14 Medicare Secondary, No-fault insurance including Auto is primary 15 Medicare Secondary Worker's Compensatic 16 Medicare Secondary Public Health Service or Other Federal Agency 41 Medicare Secondary Black Lung 42 Medicare Secondary Veteran's Administration 43 Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Pl (LGHP) 47 Medicare Secondary, Other Liability Insurance is Primary * AP Auto Insurance Policy CP Medicare Conditionally Primary * D Disability * DB Disability Benefits EP Exclusive Provider Organization HM Health Maintenance Organization (HMO)

H-2008-01: Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES)

Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME003 (cont'd)	Insurance Type Code/Product				HN Health Maintenance Organization (HMO) Medicare Advantage HS Special Low Income Medicare Beneficiary IN Indemnity * LC Long Term Care * LD Long Term Policy * LI Life Insurance * LT Litigation MA Medicare Part A MB Medicare Part B MD Medicare Part D MC Medicaid MH Medigap Part A MI Medigap Part B MP Medicare Primary PC Personal Care PE Property Insurance – Personal PR Preferred Provider Organization (PPO) PS Point of Service (POS) QM Qualified Medicare Beneficiary SP Supplemental Policy * WC Workers' Compensation * Indicates that code *is not* to be included in Vermont submissions. Included in data set for harmonization with other New England states' data collection rules.
ME004	Year	1/31/2007	Integer	4	The year for which eligibility is reported in this submission.
ME005	Month	1/31/2007	Integer	2	The month for which eligibility is reported in this submission.

H-2008-01: Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES)

Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME006	Insured Group or Policy Number	1/31/2007	Text	30	The group or policy number – not the number that uniquely identifies the subscriber.
ME007	Coverage Level Code	1/31/2007	Text	3	Benefit coverage level CHD Children Only DEP Dependents Only ECH Employee and Children EMP Employee Only ESP Employee and Spouse FAM Family IND Individual SPC Spouse and Children SPO Spouse Only
ME008	Encrypted Subscriber Unique Identification Number	1/31/2007	Text	128	The encrypted subscriber's social security number; used to create unique member ID. Set as null if unavailable.
ME009	Plan Specific Contract Number	1/31/2007	Text	128	The encrypted plan assigned contract number. Set as null if contract number equals subscriber' social security number.
ME010	Member Suffix or Sequence Number	1/31/2007	Integer	20	The unique number of the member within the contract.
ME011	Member Identification Code	1/31/2007	Text	128	The encrypted member's social security number; used to create unique member ID. Set as null if unavailable.
ME012	Individual Relationship Code	1/31/2007	Integer	2	Member's relationship to insured as shown below 01 Spouse 18 Self/Employee 19 Child 21 Unknown 34 Other Adult

Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME013	Member Gender	1/31/2007	Text	1	M Male F Female U Unknown
ME014	Member Date of Birth	1/31/2007	Date	8	CCYYMMDD
ME015	Member City Name	1/31/2007	Text	30	The city location of the member.
ME016	Member State or Province	1/31/2007	Text	2	As defined by the US Postal Service
ME017	Member ZIP Code	1/31/2007	Text	11	ZIP Code of member – may include non-US codes. Do not include dash.
ME018	Medical Coverage	1/31/2007	Text	1	Y Yes – must be mutually exclusive with MC019. N No
ME019	Prescription Drug Coverage	1/31/2007	Text	1	Y Yes – must be mutually exclusive with MC018. N No
ME020	Placeholder		Text	1	Used and or proposed by other states for – Dental coverage.
ME021	Placeholder		Text	6	Used and or proposed by other states for – Race 1.
ME022	Placeholder		Text	6	Used and or proposed by other states for – Race 2.
ME023	Placeholder		Text	15	Used and or proposed by other states for – Other Race.
ME024	Placeholder		Text	1	Used and or proposed by other states for – Hispanic indicator.
ME025	Placeholder		Text	6	Used and or proposed by other states for – Ethnicity 1.
ME026	Placeholder		Text	6	Used and or proposed by other states for – Ethnicity 2.
ME027	Placeholder		Text	20	Used and or proposed by other states for – Other Ethnicity.

H-2008-01: Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES)

Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME028	Primary Insurance Indicator	1/31/2007	Text	1	1 Yes, primary insurance 2 No, secondary or tertiary insurance
ME029	Coverage Type	1/31/2007	Text	3	ASW for self-funded plans that are administered by a third party administrator, where the employer has purchased stop-loss, or group excess, insurance coverage ASO for self funded plans that are administered by a third-party administrator, where the employer has not purchased stop-loss, or group excess insurance coverage STN for short-term non-renewable health insurance. UND for plans underwritten by the insurer OTH for any other plan. Insurers using this code shall obtain prior approval from BISHCA
ME030	Market Category Code	1/31/2007	Text	4	IND for policies sold and issued directly to individuals. (Non-group) FCH or policies sold and issued directly to individuals on a franchise basis. GCV for policies sold and issued directly to individuals as group conversion policies. GS1 for policies sold and issued directly to employers having exactly one employee GS2 for policies sold and issued directly to employers having between two and nine employees GS3 for policies sold and issued directly to employers having between 10 and 25 employees

Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME030 (cont'd)	Market Category Code	1/31/2007	Text	4	GS4 for policies sold and issued directly to employers having between 26 and 50 employees GLG1 for policies sold and issued directly to employers having between 51 and 99 employees GLG2 for policies sold and issued directly to employers having 100 or more employees GSA for policies sold and issued directly to small employers through a qualified association trust OTH For policies sold to other types of entities Insurers using this market code shall obtain prior approval from BISHCA
ME031	Placeholder		Text	3	Used and or proposed by other states for Special Coverage. 0 N/A 1 NH HealthFirst 2 VT Catamount
ME101	Encrypted Subscriber Last Name	1/31/2007	Text	128	The encrypted subscriber last name.
ME102	Encrypted Subscriber First Name	1/31/2007	Text	128	The encrypted subscriber first name.
ME103	Encrypted Subscriber Middle Initial	1/31/2007	Text	1	The encrypted subscriber middle initial.
ME104	Encrypted Member Last Name	1/31/2007	Text	128	The encrypted member last name.

H-2008-01: Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES)

Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME105	Encrypted Member First Name	1/31/2007	Text	128	The encrypted member first name.
ME106	Encrypted Member Middle Initial	1/31/2007	Text	1	The encrypted member middle initial.
ME899	Record Type	1/31/2007	Text	2	Value = ME

H-2008-01: Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES)

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC001	Payer	1/31/2007	Text	8	Payer submitting payments BISHCA Submitter Code
MC002	National Plan ID	1/31/2007	Text	30	CMS National Plan ID
MC003	Insurance Type/Product Code	1/31/2007	Text	2	12 Preferred Provider Organization (PPO) 13 Point of Service (POS) 14 Exclusive Provider Organization (EPO) 15 Indemnity Insurance 16 Health Maintenance Organization (HMO) Medicare Advantage HM Health Maintenance Organization MA Medicare Part A MB Medicare Part B MD Medicare Part D MC Medicaid OF Other Federal Program (e.g. Black Lung) TV Title V VA Veteran Administration Plan * WC Worker's Compensation * Indicates that code *is not* to be included in Vermont submissions. Included in data set for harmonization with othe New England states' data collection rules.
MC004	Payer Claim Control Number	1/31/2007	Text	35	Must apply to the entire claim and be unique within the payer's system.
MC005	Line Counter	1/31/2007	Integer	4	The line number for this service. The line counter begins with 1 and is incremente by 1 for each additional service line of a claim.

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC005A	Version Number	1/31/2007	Integer	4	The version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of that service line.
MC006	Insured Group or Policy Number	1/31/2007	Text	30	Group or policy number – not the number that uniquely identifies the subscriber.
MC007	Encrypted Subscriber Unique Identification Number	1/31/2007	Text	128	The encrypted subscriber's social security number; used to create unique member ID. Set as nul if unavailable.
MC008	Plan Specific Contract Number	1/31/2007	Text	128	The encrypted plan assigned contract number. Set as null if contract number equals subscriber's social security number.
MC009	Member Suffix or Sequence Number	1/31/2007	Integer	20	The unique number of the member within the contract.
MC010	Member Identification Code	1/31/2007	Text	128	The encrypted member's social security number; used to create unique member ID. Set as null if unavailable.
MC011	Individual Relationship Code	1/31/2007	Integer	2	Member's relationship to insured as shown below: 01 Spouse 04 Grandfather or Grandmother 05 Grandson or Granddaughter 07 Nephew or Niece 10 Foster Child 15 Ward 17 Stepson or Stepdaughter

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC011 (cont'd)	Individual Relationship Code (cont'd)				19 Child 20 Employee/Self 21 Unknown 22 Handicapped Dependent 23 Sponsored Dependent 24 Dependent of a Minor Dependent 29 Significant Other 32 Mother 33 Father 36 Emancipated Minor 39 Organ Donor 40 Cadaver Donor 41 Injured Plaintiff 43 Child Where Insured Has No Financial Responsibility 53 Life Partner 76 Dependent
MC012	Member Gender	1/31/2007	Text	1	M Male F Female U Unknown
MC013	Member Date of Birth	1/31/2007	Date	8	CCYYMMDD
MC014	Member City Name	1/31/2007	Text	30	The city name of the member.
MC015	Member State or Province	1/31/2007	Text	2	As defined by the US Postal Service
MC016	Member Zip Code	1/31/2007	Text	11	ZIP Code of member – may include non-US code Do not include dash.
MC017	Date Service Approved/ Accounts Payable Date/ Actual Paid Date	1/31/2007	Date		CCYYMMDD

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Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC018	Admission Date	1/31/2007	Date	8	Required for all inpatient claims. CCYYMMDD
MC019	Admission Hour	1/31/2007	Integer	4	Required for all inpatient claims. Time is expressed in military time – HHMM
MC020	Admission Type	1/31/2007	Integer	1	Required for all inpatient claims. Refer to Appendix A.
MC021	Admission Source	1/31/2007	Text	1	Required for all inpatient claims. Refer to Appendix A.
MC022	Discharge Hour	1/31/2007	Integer	4	Hour in military time – HHMM
MC023	Discharge Status	1/31/2007	Integer	2	Required for all inpatient claims. 01 Discharged to home or self care 02 Discharged/transferred to another short term general hospital for inpatient care 03 Discharged/transferred to skilled nursing facility (SNF) 04 Discharged/transferred to nursing facility (NF) 05 Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution 06 Discharged/transferred to home under care of organized home health service organizatior 07 Left against medical advice or discontinued care 08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an inpatient to this hospital

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC023 (cont'd)	Discharge Status (cont'd)				20 Expired 30 Still patient or expected to return for outpatient services 40 Expired at home 41 Expired in medical facility 42 Expired, place unknown 43 Discharged/transferred to a Federal Hospital 50 Hospice – home 51 Hospice – medical facility 61 Discharged/transferred within this institution to a hospital-based Medicare-approved swing bed 62 Discharged/transferred to an inpatient rehabilitation facility including distinct parts of a hospital 63 Discharged/transferred to a long term care hospital 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
MC024	Service Provider Number	1/31/2007	Text	30	Payer assigned provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change. In many cases, it will be the provider Medicare number.
MC025	Service Provider Tax ID Number	1/31/2007	Text	10	Federal taxpayer's identification number.

H-2008-01: Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES)

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC026	National Service Provider ID	1/31/2007	Text	20	Required if National Provider ID is mandated for use under HIPAA. The preferred code for this element is for the rendering provider. For the billing provider, see MC077.
MC027	Service Provider Entity Type Qualifier	1/31/2007	Text	1	HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a "person", and these shall be coded as a person. Insurers and health care processors shall code according to: 1 Person 2 Non-Person Entity
MC028	Service Provider First Name	1/31/2007	Text	25	Individual first name. Set to null if provider is a facility or organization
MC029	Service Provider Middle Name	1/31/2007	Text	25	Individual middle name or initial. Set to null if provider is a facility or organization
MC030	Service Provider Last Name or Organization Name	1/31/2007	Text	60	Full name of provider organization or last name of individual provider.
MC031	Service Provider Suffix	1/31/2007	Text	10	Suffix to individual name. Set to null if provider is a facility or organization The service provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III.), if applicable, rather than the clinician's degree (e.g., MD, LCSW).

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC032	Service Provider Specialty	1/31/2007	Text	50	As defined by payer Dictionary for specialty code values must be supplied during testing.
MC033	Service Provider City Name	1/31/2007	Text	30	City name of provider and preferably the practic location.
MC034	Service Provider State or Province	1/31/2007	Text	2	As defined by the US Postal Service.
MC035	Service Provider ZIP Code	1/31/2007	Text	11	ZIP Code of provider – may include non-US codes. Do not include dash.
MC036	Type of Bill – Institutional/ Facility Claims, such as those submitted using on UB04 forms	1/31/2007	Integer	2	Required for institutional claims. Not to be used for professional claims. **Type of Facility – First Digit** 1 Hospital 2 Skilled Nursing 3 Home Health 4 Christian Science Hospital 5 Christian Science Extended Care 6 Intermediate Care 7 Clinic 8 Special Facility **Bill Classification – Second Digit if First Digit = 1-6** 1 Inpatient (Including Medicare Part A) 2 Inpatient (Medicare Part B Only) 3 Outpatient 4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment)

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC036 (cont'd)	Type of Bill – Institutional/ Facility Claims (cont'd)				5 Nursing Facility Level I 6 Nursing Facility Level II 7 Intermediate Care – Level III Nursing Facility 8 Swing Beds **Bill Classification – Second Digit if First Digit = 7** 1 Rural Health 2 Hospital Based or Independent Renal Dialysis Center 3 Free Standing Outpatient Rehabilitation Facility (ORF) 5 Comprehensive Outpatient Rehabilitation Facilities (CORF) 6 Community Mental Health Center 9 Other **Bill Classification – Second Digit if First Digit = 8** 1 Hospice (Non Hospital Based) 2 Hospice (Hospital-Based) 3 Ambulatory Surgery Center 4 Free Standing Birthing Center 9 Other
MC037	Site of Service – on NSF/CMS 1500 Claims	1/31/2007	Text	2	Required for professional claims. Not to be used for institutional claims. 11 Office 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room – Hospital

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC037 (cont'd)	Site of Service – on NSF/CMS 1500 Claims (cont'd)				24 Ambulatory Surgery Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 35 Boarding Home 41 Ambulance – Land 42 Ambulance – Air or Water 50 Federal Qualified Center 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 60 Mass Immunization Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End Stage Renal Disease Treatment Facility 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory 99 Other Unlisted Facility

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Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC038	Claim Status	1/31/2007	Integer	2	01 Processed as primary 02 Processed as secondary 03 Processed as tertiary 04 Denied 19 Processed as primary, forwarded to additional payer(s) 20 Processed as secondary, forwarded to additional payer(s) 21 Processed as tertiary, forwarded to additional payer(s) 22 Reversal of previous payment
MC039	Admitting Diagnosis	1/31/2007	Text	5	Required on all inpatient admission claims and encounters using the ICD-9-CM. Do not code decimal point.
MC040	E-Code	1/31/2007	Text	5	Describes an injury, poisoning or adverse effect using the ICD-9-CM. Do not include decimal point.
MC041	Principal Diagnosis	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC042	Other Diagnosis – 1	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC043	Other Diagnosis – 2	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC044	Other Diagnosis – 3	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC045	Other Diagnosis – 4	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC046	Other Diagnosis – 5	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC047	Other Diagnosis – 6	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC048	Other Diagnosis – 7	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC049	Other Diagnosis – 8	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.

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Appendix D1 Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC050	Other Diagnosis – 9	1/31/2007	Integer	5	ICD-9-CM Do not code decimal point
MC051	Other Diagnosis – 10	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point
MC052	Other Diagnosis – 11	1/31/2007	Text	5	ICD-9-CM Do not code decimal point
MC053	Other Diagnosis – 12	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point
MC054	Revenue Code	1/31/2007	Integer	4	National Uniform Billing Committee Codes Code using leading zeroes, left justified and four digits
MC055	Procedure 1 Code	1/31/2007	Text	5	Health Care Common Procedural Coding System (HCPCS) This includes the CPT codes of the American Medical Association
MC056	Procedure 1 Modifier – 1	1/31/2007	Text	2	Procedure modifier required when a modifier clarifies or improves the reporting accuracy of the associated procedure code When the insurer utilizes a local code system for modifier, a reference table shall be submitted.
MC057	Procedure 1 Modifier – 2	1/31/2007	Text	2	Procedure modifier required when a modifier clarifies or improves the reporting accuracy of the associated procedure code When the insurer utilizes a local code system for modifier, a reference table shall be submitted
MC058	ICD-9-CM Procedure Code	1/31/2007	Text	4	Primary ICD-9-CM code for this line of service Do not code decimal point
MC059	Date of Service – Form	1/31/2007	Date	8	First date of service for this service line CCYYMMDD

H-2008-01: Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES)

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC060	Date of Service – Thru	1/31/2007	Date	8	Last date of service for this service line. CCYYMMDD
MC061	Quantity	1/31/2007	Integer	3	Count of services performed, which shall be set equal to one on all observation bed service lines and should be set equal to zero on all other room and board service lines, regardless of the length of stay.
MC062	Charge Amount	1/31/2007	Decimal	10	Do not code decimal point.
MC063	Paid Amount	1/31/2007	Decimal	10	Includes any withhold amounts. Do not code decimal point. This element includes all payment made by the insurer except capitation.
MC064	Prepaid Amount	1/31/2007	Decimal	10	For capitated services – the fee for service equivalent amount. Do not code decimal point.
MC065	Co-pay Amount	1/31/2007	Decimal	10	The preset, fixed dollar amount for which the individual is responsible. Do not code decimal point.
MC066	Coinsurance Amount	1/31/2007	Decimal	10	The dollar amount an individual is responsible for – not the percentage. Do not code decimal point.
MC067	Deductible Amount	1/31/2007	Decimal	10	The dollar amount of the deductible. Do not code decimal point.
MC068	Patient Account/Control Number	1/31/2007	Text	20	Number assigned by hospital.

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Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC069	Discharge Date	1/31/2007	Date	8	Date patient discharged. Required for all inpatient claims. CCYYMMDD
MC070	Service Provider Country Name	1/31/2007	Text	30	Code US for United States.
MC071	DRG	1/31/2007	Text	10	Insurers and health care claims processors shall code using the CMS methodology when available Precedence shall be given to DRGs transmitted from the hospital provider. When the CMS methodology for DRGs is not available, but the All Payer DRG system is used, the insurer shall format the DRG and the complexity level within the same field with an "A" prefix, and with a hyphen separating the DRG and the complexity level (e.g. AXXX-XX)
MC072	DRG Version	1/31/2007	Text	2	Version number of the grouper used.
MC073	APC	1/31/2007	Text	4	Insurers and health care claim processors shall code using the CMS methodology when available Precedence shall be given to APCs transmitted from the health care provider.
MC074	APC Version	1/31/2007	Text	2	Version number of the grouper used.
MC075	Drug Code	1/31/2007	Text	11	Insurers and health care claims processor shall code according to NDC code.
MC076	Billing Provider Number	1/31/2007	Text	30	Payer assigned provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change.

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Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC077	National Billing Provider ID	1/31/2007	Text	20	National Provider ID mandated for use under HIPAA.
MC078	Billing Provider Last Name	1/31/2007	Text	60	Full name of billing organization or last name of individual billing or Organization Name.
MC101	Encrypted Subscriber Last Name	1/31/2007	Text	128	The encrypted subscriber last name.
MC102	Encrypted Subscriber First Name	1/31/2007	Text	128	The encrypted subscriber first name.
MC103	Encrypted Subscriber Middle Initial	1/31/2007	Text	1	The encrypted subscriber middle initial.
MC104	Encrypted Member Last Name	1/31/2007	Text	128	The encrypted member last name.
MC105	Encrypted Member First Name	1/31/2007	Text	128	The encrypted member first name.
MC106	Encrypted Member Middle Initial	1/31/2007	Text	1	The encrypted member middle initial.
MC899	Record Type	1/31/2007	Text	2	Value = MC

HAWAII ADMINISTRATIVE RULES

TITLE 12 DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

SUBTITLE 3

DISABILITY COMPENSATION DIVISION

CHAPTER 12

PREPAID HEALTH CARE

SUBCHAPTER 1

GENERAL

§12-12-1 Definitions. As used herein:

"Continuation of coverage in case of inability to earn wages" means that allocation of health care premium will be based on an employee's continuing salary, if this be the case, or the salary or wages that the employee received in the last fully completed month prior to the disability. Thus, the employer must continue the coverage by paying for the employer's share of the premium and the employee must contribute towards the premium to the same extent as prior to the disability.

"Covered employee" means an eligible employee who is provided health care coverage by an employer.

"Department" shall be as defined in section 393-3, HRS.

"Director" shall be as defined in section 393-3, HRS.

"Eligible employee" means an employee who has worked for an employer for twenty or more hours a week for four consecutive weeks, and earned 86.67 times the Hawaii minimum hourly wage.

"Employer" shall be as defined in section 393-3, HRS.

"Employment" shall be as defined in section 393-3, HRS, and shall include the period an employee is receiving benefits under chapters 386 or 392, HRS, for a period of not less than that prescribed in section 393-15, HRS. It shall also include services performed by an individual for wages or under any contract of hire irrespective of whether the common-law relationship of master and servant exists unless and until it is shown to the satisfaction of the director that:

(1) The individual has been and will continue to be free from control or direction over the performance of the service, both under the contract of hire and in fact;

(2) The service is either outside the usual course of the business for which the service is performed or that the service is performed outside of all the places of business of the enterprise for which the service is performed; and

(3) The individual is customarily engaged in an independently established trade, occupation, profession or business of the same nature as that involved in the contract of service.

"Four consecutive weeks" means any consecutive period of four weeks which an employee worked for an employer.

"Health care contract" means the entire approved plan of the health care contractor including its terms and conditions and benefit schedule.

"Premium" shall be as defined in section 393-3, HRS.

"Prepaid health care contractor" shall be as defined in section 393-3, HRS.

"Prepaid health care plan" shall be as defined in section 393-3, HRS. Prepaid health care plans which have the largest number of subscribers in the State are on file with the state department of labor and industrial relations, disability compensation division, and are available upon request.

"Regular employee" shall be as defined in section 393-3, HRS, but does not include dependents of an employee who are covered by a health care plan as an employee of the same employer.

"Regular wages" include an employee's disability income insurance provided for and paid entirely by the employer in excess of that required by any law.

"Seasonal employment" means employment by an employer defined in the second sentence of section 393-3(8), HRS, during its seasonal period or seasonal periods.

"Seasonal period or "seasonal periods" means the period or periods of seasonal activity of less than an aggregate of twenty-six calendar weeks in twelve consecutive calendar months in which the volume of employment by the employer in the pursuit, measured in terms of average weekly man hours per week, is at least fifty percent more than the average weekly man hours of employment by the employer in the twelve consecutive weeks in such twelve consecutive calendar months when the volume of employment by the employer is the lowest in such pursuit; provided that employment by an employer in seasonal pursuit engaged in the cultivating, harvesting, and processing of coffee and macadamia nuts and other crops or products constitutes seasonal employment during the employer's seasonal period or seasonal periods, provided further that employment during the seasonal period or seasonal periods by an employer engaged in the cultivating, harvesting, processing, canning, and warehousing of pineapples constitutes seasonal employment.

"Self-insurer" means an employer as defined in section 393-3, HRS, who undertakes to provide the prescribed coverage and benefits directly to the employees without the intervention of a plan provided by a health care contractor or insurer subject to the insurance laws of the State.

"Statute" means chapter 393, HRS, entitled "Prepaid Health Care Act."

"Wages" shall be as defined in section 393-3, HRS.

"Week" means a period of seven consecutive days based on the established work week of each employer. [Eff: 5/7/81; am 9/16/85; am 1/13/92; am 8/19/96] (Auth: HRS §393-32) (Imp: HRS §§393-1, 393-3, 393-4, 393-5, 393-7, 393-11, 393-15)

§12-12-2 Determination of seasonal pursuit and seasonal period. (a) Employers believing themselves to be engaged in seasonal pursuits shall file a request for such determination with the director. The request shall contain data and information necessary to qualify the employer within the provisions as set forth in section 12-12-1 of this chapter and also as set forth in section 393-3(8), HRS, for the twelve months immediately preceding the date of the request for seasonal pursuit determination. The request shall also include similar data and information anticipated to be experienced in the current twelve month period. The request shall be signed by an authorized representative of the employer.

(b) The department shall review the request and information submitted and make determinations of seasonal pursuit and seasonal period or seasonal periods conforming to section 12-12-1. The decision of the department shall be certified in writing to the requesting employer and will remain in effect for the period specified in the decision.

(c) In order to establish the seasonal period or periods for each subsequent twelve month period

following initial determination by the department, the employer shall resubmit data and information specified in subsections (a) and (b) not later than one calendar month after the expiration date of the department's decision. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-3)

§12-12-3 Voluntary Coverage. An employer may voluntarily cover a person excluded under section 393-5, HRS, with a plan which will afford the person health care protection. Such voluntarily covered person shall not be entitled to the protection afforded by the statute or this chapter. [Eff: 5/7/81] (Auth: HRS § 393-32) (Imp: HRS §§393-2, 393-5)

§12-12-4 Monthly pay of regular employee. The monthly wages for the purposes of section 393-11, HRS, shall be 86.67 times the State's minimum wage rounded off to the next higher dollar. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-11)

§12-12-5 Employee responsibility. An employee exempt under the statute shall immediately file with the employer on a form provided by the department the reason for such exemption. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-15, 393-16, 393-17, 393-18, 393-21)

§12-12-6 Employee already disabled. Should an employer elect to change the health care plan or contractor while an employee is disabled, the employer shall provide a reasonable extension of benefits, which may be provided by the previous or succeeding

health care contractor. [Eff: 5/7/81; am 6/19/86] (Auth: HRS §393-32) (Imp: HRS §§393-12, 393-15)

§12-12-7 Health care advisory council. The council shall have discretion in determining which plans qualify under section 393-7, HRS. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-7)

§12-12-8 Director's rights and duties. The director's rights and duties shall be that prescribed by chapters 371 and 393, HRS. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-31, 393-32)

§§12-12-9 to 12-12-10 (Reserved)

SUBCHAPTER 2

PLANS

§12-12-11 Coverage. An employer may provide an approved individual or a group plan. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-11, 393-12, 393-13, 393-14, 393-15)

§12-12-12 More than one plan. An employer may elect to provide more than one approved plan from the same or different health care contractor. The employer shall not be liable for more than the cost of the least expensive plan should there be more than one plan. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-12)

§12-12-13 Classes of employees. An employer may provide different plans for different classes of employees. The employer shall not, however, exceed

the withholding requirements of section 393-13, HRS, should classes of employees be provided different plans. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-12, 393-13)

§12-12-14 Out-of-state employer-sponsored plans. Any employer-sponsored plan shall be submitted to the department by the authorized health care contractor in accordance with section 12-12-16. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-20)

§12-12-15 Collective bargaining agreement. Any prepaid health care plan included in a collective bargaining agreement:

(1) Is presumed to meet the requirements of the statute if the agreement is dated prior to June 3, 1978.

(2) Shall meet the requirement of the statute if the agreement is dated on or after June 3, 1978.

(3) Shall be filed by the employer with the department immediately upon approval of the parties whenever effected, modified, renegotiated, or extended. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-19)

§12-12-16 Submission of plans by health care contractors. (a) After the approval of a health plan by the Hawaii State Insurance Commissioner or a signed statement that the plan does not require approval, the health care contractor shall submit eight copies of the plan to the department for review.

Each plan shall have attached thereto the evidence of the insurance commissioner's approval or the statement that the plan does not require approval. Any plan submitted under section 393-7(b), HRS, which provides aggregate benefits that are more limited than those provided by plans qualifying under section 393-7(a), HRS, shall include certification that the employer has agreed to contribute at least one-half of the cost of the coverage of dependents under such plan.

(b) After written advice from the prepaid health care advisory council, the director shall notify the health care contractor of the proposed approval or disapproval of the plan. Any proposal to disapprove shall contain the reasons therefor.

(c) The health care contractor may apply for reconsideration in writing within fifteen days after receipt of the proposed disapproval. The request for reconsideration shall include a memorandum of the facts on the basis of which the contractor contends that the plan meets the requirements of section 393-7, HRS.

(d) The director shall notify the health care contractor of the final decision to approve or disapprove the plan. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-32)

§12-12-17 Employer's obligation. (a) Each employer shall inform an eligible employee of the entitlement afforded by this statute by providing the health care contractor's name, plan number, group

number, effective date of coverage, and employee's cost.

(b) The employer shall give each covered employee thirty days' notice should the employer elect to change the employer's plan or health care contractor.

(c) Any employer who withholds premium payments shall provide a covered employee who is incapacitated due to illness or injury, the following information in writing:

(1) Within two weeks of the disability date, the amount the employee is required to pay directly to the employer for forwarding to the health care contractor in order to continue coverage under section 393-15, HRS.

(2) At least two weeks prior to the date an employer will have completed the employer's obligation under section 393-15, HRS, the entire premium cost the employee is required to pay directly to the employer for forwarding to the health care contractor in order to continue coverage. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-11, 393-12, 393-13, 393-14, 393-15)

§12-12-18 supplemental coverage to required health care benefits. (a) When a health care contractor whose health care plan has been approved pursuant to section 393-7, HRS, subsequently provides supplemental benefits such as vision, drug, and dental coverage, these supplemental benefits shall then become a part of the employer's health care plan

whether or not initiated by employer or employees. When current or future employees must subscribe to such health care plan without having the option of excluding the supplemental benefits and its applicable cost, the cost of the required health care and supplemental benefits shall become the basis for allocation of premium specified in section 393-13, HRS.

(b) If an employee can choose not to accept the supplemental benefits, the employer may require an employee who elects the coverage to pay for the cost of the supplemental benefits. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-12, 393-13, 393-15)

§§12-12-19 to 12-12-23 (Reserved)

SUBCHAPTER 3

HEALTH CARE CONTRACTOR REQUIREMENTS

§12-12-24 Self-insurer. Any self-insurer may qualify as a health care contractor upon furnishing satisfactory proof to the director of its solvency and financial ability to defray or reimburse in whole or in part the expenses of health care under an approved health care plan. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-12)

§12-12-25 Health care contractor. Every health care contractor required to be licensed by the Hawaii State Insurance Commissioner shall be so licensed before submission of plans to the department. [Eff:

5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-3, 393-7, 393-12)

§12-12-26 The health care insurance contract. (a) Every health care contract of insurers subject to the insurance laws of the State, including any amendment, endorsement, or rider to a contract, which provides for benefits under section 393-7, HRS shall be approved by the Hawaii State Insurance Commissioner prior to submission to the director under section 12-12-16.

(b) Nothing in the statute or this chapter is intended to amend, modify or change any policy form approval requirements prescribed in the State insurance laws. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-12)

§12-12-27 The health care certificate. (a) Every covered employee shall be given written evidence of health care coverage by the employer, which has been provided by the health care contractor.

(b) The health care contractor shall permit continuation of coverage without any diminution of benefits or standards from the plan with which an employee was covered prior to disability during the period specified in section 393-15, HRS. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-12, 393-14, 393-15)

§12-12-28 Cancellation of contract. (a) No health care contractor shall cancel a contract providing in whole or in part for health care benefits

required by the statute prior to the expiration date of the contract unless written notice of intention to cancel on a specified date and reason therefor has been filed with and served on the employer and the director at least ten days prior to the specified cancellation date.

(b) The ten days' advance notice requirement in subsection (a) need not be complied with when a new contractor is simultaneously substituted. In the event of substitution, the previous contractor shall immediately file with and serve on the employer and the director, notice that the contract was canceled, the specific date and the reason for cancellation.

(c) If a plan provides by its terms for an expiration date, acceptance of the plan by the director is notice thereof.

(d) The employer shall notify its covered employees of the cancellation of coverage for nonpayment of premium. The employees shall be given an option of individual coverage if premium payment is made within ten days directly to the contractor. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-12, 393-13)

§12-12-29 Refusal to insure. No health care contractor other than a self-insurer shall refuse to cover any employer-applicant except for the nonpayment of premiums. The health care contractor shall notify the director of all refusals to insure. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-3, 393-7, 393-12, 393-13)

§12-12-30 Disqualification for benefits. Subject to the terms of the health care contract, a covered employee shall not be disqualified for benefits by a health care contractor except for the nonpayment of premium. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-11, 393-13)

§12-12-31 Agent. Each health care contractor shall provide the department with the name of an employee or officer of the contractor who is in direct charge of health care matters to whom all correspondence should be addressed. The person should be one who can be reasonably expected to expedite matters relating to the statute. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-3, 393-32)

§12-12-32 Contractors of union plans. Except as to section 12-12-16, all health care contractors, including self-insurers, providing benefits in accordance with a collective bargaining agreement shall comply with all the requirements of the statute and this chapter. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-2, 393-11, 393-12, 393-14, 393-15)

§12-12-33 Contractors of approved plans. Prepaid health care contractors with plans approved pursuant to section 393-7, HRS, are required to submit to the department of labor and industrial relations every December 31 the number of subscribers enrolled under each of their plans. If the subscriber count of one of their plans exceeds the count of their plan with the largest number of subscribers, the department must be notified within thirty days of

such change. [Eff: 8/19/96] (Auth: HRS §393-32) (Imp: HRS §393-7)

§§12-12-34 to 12-12-40 (Reserved)

SUBCHAPTER 4

BENEFITS AND CLAIMS PROCEDURE

§12-12-41 Withholding by employers. (a) An employer electing to withhold from covered employees may withhold the proportionate cost of the premium each pay period beginning in the month the employees' coverage becomes effective. In no event shall the employer withhold premiums less often than once monthly. An employer shall not withhold more than 1.5 percent of such employee's regular wages or one-half the cost of premium, whichever is less, during each calendar month.

(b) Withholdings by an employer shall be promptly paid to the health care contractor in accordance with the billing requirements of the contractor.

(c) Any employer fails to transmit payments to the health care contractor in accordance with the billing requirements of the contractor shall be penalized as provided under section 393-33, HRS.

(d) In the event an employer withholds but fails to obtain coverage from a health care contractor, the employer shall:

(1) Be liable for all health care expenses incurred by the employee.

(2) Refund the withheld premium to all employees.

(3) Be subject to penalties prescribed by section 393-33, HRS. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-13, 393-15, 393-24)

§12-12-42 Deductions greater than authorized. (a) In the event an employer withholds more than authorized by section 393-13, HRS, the employer shall:

(1) Refund such excess withholdings to the employee.

(2) Be subject to penalties prescribed by section 393-33, HRS.

(b) If an employee is no longer employed by the employer and cannot be located, the employer shall deposit such sum in the premium supplementation fund. The employer shall provide the director with the employee's full name, social security account number, last known address, the amount due, and any other information requested by the director. The director shall endeavor to locate such employee to return such deductions. If the employee cannot be located for a period of two years from the date of deposit, the director shall cause such moneys to become a part of the premium supplementation fund. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-13, 393-41)

§12-12-43 Notice and proof of claim. (a) Any covered employee claiming benefits or someone acting

in behalf of the employee shall furnish a written claim to the health care contractor pursuant to the health care contract.

(b) The claim shall include documents required by the health care contract. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-7)

§12-12-44 Denial of claim. (a) If an employee's claim is denied by a health care contractor in whole or in part because of nonpayment of premium, notice of denial in a form prescribed by the director shall be mailed promptly to the employee.

(b) If an employee desires a review of the denied claim, the employee shall file the prescribed notice of denial and a statement giving specific reasons for the request with the director. The request for review shall be filed within twenty days after the date of denial at the office of the department in the county in which the claimant resides or to any office of the department. The director shall forthwith notify the health care contractor of the claimant's request for review, enclosing a copy of the claimant's reasons therefor.

(c) The director, or an officer or employee designated by the director for that purpose, shall investigate the request and render a decision. The decision is final with right of appeal in accord with section 91-14, HRS. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-32)

§12-12-45 Controverted workers' compensation claims. In the event of a controverted workers'

compensation claim, the health care contractor shall pay or provide for the medical services in accordance with the health care contract and notify the department of such action. If workers' compensation liability is established, the health care contractor shall be reimbursed by the workers' compensation carrier such amounts authorized by chapter 386, HRS, and chapter 10 of title 12, administrative rules. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 392[sic]-32)

§12-12-46 Experience rating. If, after the end of a policy year, the employer receives an experience rating credit or a dividend from the health care contractor, the employee's share of the experience rating credit or dividend shall be refunded by the employer or applied to future premium payments of covered employees. "Employee's share" means the mathematical ratio of employer-employee contributions of the experience rating credit or dividend proportionately divided among all covered employees by months of service for the period of credit. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-13)

§§12-12-47 to 12-12-59 (Reserved)

SUBCHAPTER 5

REPORTS

§12-12-60 Health care contractors. (a) Health care contractors shall submit a monthly report, in a

form designated by the department, showing the following information:

(1) Name of newly enrolled or terminated employer;

(2) State department of labor and industrial relations account number as assigned by the unemployment insurance division;

(3) Plan number;

(4) Group number;

(5) Effective date of coverage; and

(6) Effective date and reason for cancellation.

(b) On April 15 of each year, health care contractors shall file an annual report for each employer and for each plan covering the most recently completed calendar year. This report shall be on a form prescribed by the director and shall contain the following information:

(1) Number of covered employees employed on the twelfth day of the month for each month of the year.

(2) Number of covered employees providing coverage for their dependents for each month of the year; and

(3) Amount returned to the employer due to experience rating credit or dividend during the year.

(c) On April 15 of each year, the following consolidated information shall be furnished by health

care contractors for all employers covered by such contractor:

(1) Number of claims filed by covered employees;

(2) Number of claims paid to covered employees; and

(3) Amount of claims paid to covered employees.

(d) If coverage is provided through an association of employers or to employers through a collectively bargained health and welfare type trust fund or similar arrangement, and it is not feasible to obtain information for each employer in the association or trust fund, the health care contractor may file a consolidated report in a form prescribed by the director. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-32)

§12-12-61 Employers. (a) On April 15 of each year, all employers providing coverage through a health care contractor shall file an annual report for each plan covering the most recently completed calendar year. This report shall be on a form prescribed by the director and shall provide the following information:

(1) Amount of total wages paid to covered employee;

(2) Amount of employer contributions paid in the year, and

(3) Amount of covered employee contributions paid in the year, if applicable.

(b) On April 15 of each year, employers who provide health care benefits directly to their employees shall file an annual report for each plan covering the most recently completed calendar year. This report shall be on a form prescribed by the director and shall provide the following information:

(1) Number of covered employees employed on the twelfth day of each month;

(2) Amount of total wages paid to covered employees;

(3) Amount of employer contributions paid in the year;

(4) Amount of covered employee contributions paid in the year, if applicable; and

(5) Amount returned to the employer due to experience rating credit or dividends, if applicable. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-32)

§12-12-62 Principal and secondary employer. (a) Any principal employer who is informed by an employee to be the secondary employer shall immediately notify the department of such change on the form provided by the department.

(b) Any secondary employer who is subsequently informed by an employee to be the principal employer shall immediately notify the department of such change on the form provided by the department. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-6, 393-16)

§12-12-63 Other employer reports. (a) Status report. Every employer for whom services are performed in employment shall file a report on a form prescribed by the director to determine liability for coverage within ten days after the status report form is mailed by the department. This report shall provide information such as: name of health care contractor, plan number, group number, effective date of plan, number of employees who claim exemption and reason thereof, and employer-employee premium cost for individual and dependents coverage. The employer's health care plan shall accompany this report, if the plan has not been approved by the director.

(b) Employer shall give the department thirty days written notice prior to change in health care plan or health care contractor.

(c) Employee notification to employer.

(1) Any employer whose employee claims exemption from the statute shall file a statement signed by the employee on a form provided by the department. The form shall be filed within ten days of employment or change in status.

(2) On December 31 of each year, each employer shall refile a statement signed by all employees who claim exemption from the statute on a form prescribed by the department. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-17, 393-21)

§12-12-64 Posting of notice of coverage. Each employer shall post and maintain in a conspicuous place or places in and about the place of business type-written or printed notices stating that the employer has obtained health care coverage required by law, in the form as may be prescribed by the director. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-32)

§§12-12-65 to 12-12-69 (Reserved)

SUBCHAPTER 6

PREMIUM SUPPLEMENTATION

§12-12-70 Entitlement to premium supplementation. (a) "Less than eight employees" shall mean the total number of employees who are entitled to and covered as of the twelfth day of each calendar month. An employer who provides coverage to eight or more employees entitled to coverage in a month shall not qualify for premium supplementation for that month.

(b) An employer must be in business for profit to qualify for premium supplementation.

(c) Premium supplementation for the employer's taxable year shall be awarded for those months in that taxable year in which the employer satisfies the requirements of section 393-45, HRS. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-45)

§12-12-71 Claim for premium supplementation. (a) A claim for premium supplementation for an employer's taxable year shall be filed with the department within two years after the end of such year. Any claim filed after two years shall not be honored.

(b) The premium supplementation claim shall be filed on a form designated by the department. The claim shall be accompanied by the employer's federal and state tax returns for the years claimed and all books of accounts as may be requested by the department.

(c) Premium supplementation shall be paid rounded off to the nearest dollar. A claim for less that [sic] $1 shall not be processed or paid. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-47)

§12-12-72 Reduction of premium supplementation. (a) The amount of premium supplementation due shall be reduced by the experience rating credit or dividend received by the employer from a health care contractor.

(b) If an experience rating credit or dividend is received after the premium supplementation is paid to the employer, the department shall reduce any premium supplementation awarded within the next two years by the employer's share of the amount of such experience rating credit or dividend. [Eff 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-45)

§12-12-73 Coverage by the fund. (a) Notwithstanding section 12-12-41(d), the premium supplementation fund shall provide benefits to an eligible employee whose employer has failed to provide coverage in the following manner:

(1) The eligible employee shall be deemed to have selected the most prevalent reimbursement plan if the services were obtained from a health care provider normally paid by such plan.

(2) The eligible employee shall be deemed to have selected the most prevalent fee for service plan if services were obtained from a fee for services health care provider.

(b) The premium supplementation fund shall reimburse the eligible employee for payment of fees based on subsection (a)(1) or (2) less the premium the employee would have paid for such coverage. A claim for reimbursement shall be filed on a form provided by the director within two years after such services are provided, and shall contain a certification by the eligible employee that the employer has refused a written request to provide the required benefits to the eligible employee. An employer shall be deemed to have refused to provide such benefits where the employer fails to contact such eligible employee within thirty calendar days after such eligible employee makes a written request to the employer for such benefits at the employer's place of business.

(c) Any employee who is eligible for or received benefits under other laws shall not be entitled to benefits under this section.

(d) The health care contractor with the most prevailing plan selected in the category of subsection (a)(1) or (2) shall assist the department, upon request, in arriving at the proper reimbursement to the eligible employee. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-48)

§§12-12-74 to 12-12-75 (Reserved)

SUBCHAPTER 7

PENALTIES

§12-12-76 Penalties. Penalties under section 393-33, HRS, shall be assessed by the director, or a designated representative, after hearings held in accordance with chapter 91, HRS. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-33)

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF VERMONT

Liberty Mutual Insurance Company, Plaintiff v. Stephen W. Kimbell, in his capacity as the Vermont Commissioner of Banking, Insurance, Securities and Health Care Administration, Defendant.	)	Docket No. 2:11-cv-00204-wks

AFFIDAVIT OF DIAN KAHN

Dian Kahn, having been sworn, states the following under oath:

1. I am an employee of the Vermont Department of Financial Regulation ("the Department"). Until the spring of 2012, the Department was known as the Department of Banking, Insurance, Securities and Health Care Administration.

2. I am the Director of Analysis & Data Management for the Division of Health Care Administration for the Department. In this capacity, I administer the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES). I have served in this position since at least 2000. I have been employed by the Department for approximately 17 years.

3. Blue Cross Blue Shield of Massachusetts (BCBSMA) reports data and membership information to the VHCURES.

4. I have reviewed the VHCURES data from Calendar Year 2010, the most recently completed data set. Section 5 and 6 (below) refer to Calendar Year 2010.

5. BCBSMA reported a total of 5,701 average members (members per month). BCBSMA reported a total of 2,511 average members for self-funded plans for which it provides primarily or exclusively administrative services as the third-party administrator, including plans for which BCBSMA provided stop-loss insurance in addition to providing administrative services. Most, if not all, of those plans are assumed to be ERISA plans. Liberty Mutual's plan is among those that BCBSMA provides administrative services for.

6. BCBSMA reported on a total of 7,605 unique members (including members who are only briefly or partially enrolled in a plan that BCBSMA reports on). BCBSMA reported on a total of 3,667 unique members for self-funded for which it provides primarily or exclusively administrative services as the TPA. Most, if not all, of those plans are assumed to be ERISA plans.

Further affiant sayeth naught.

/s/ Dian Kahn
Dian Kahn

Subscribed and sworn to before me on this 13th day of August, 2012.

/s/ Diane L. Lewis
Notary Public

My Commission Expires: 2/10/15

State Health Reporting Laws

Summary Table

STATE	NAME OF PROGRAM/ RESPONSIBLE STATE AGENCY	PRIMARY STATUTE/ RULES & REGULATIONS	INFORMATION GENERALLY TO BE REPORTED	ENTITIES GENERALLY COVERED BY STATUTE
Colorado	*Program* Colorado All Payer Claims Database *Agency* Center for Improving Value in Health Care (CIVHC)	*Year Statute Enacted* 2010 *Statute* Colo Rev Stat § 25 5-1-204 (2010) *Rules & Regulations* 10 C C R 2505-5	Eligibility data files, medical and pharmacy claims data files Required information includes Name, extraction date, social security number, contract number; gender, date of birth, address, medical coverage, race, ethnicity, service provider specialty, etc	Colorado generally collects data from public and private health care payers "Private health care payer" is defined as an "insurance carrier covering an aggregate of 1,000 enrolled lives " 10 C C R 2505-5 at 1 200 1 The term "insurance carrier" is expressly limited to entities "subject to the insurance laws and regulations of Colorado " C R S § 10-16-102(8) As currently set up, Colorado's database "won't have information" on employees who receive benefits from "self-insured" companies' plans http://civhc org/getmedia/8c3f2d6c-4cc0-4675-8c21-88ca1a60bcaf/APCD-FAQs_4 2012 pdf aspx (p 6)

State Health Reporting Laws

Summary Table

STATE	NAME OF PROGRAM/ RESPONSIBLE STATE AGENCY	PRIMARY STATUTE/ RULES & REGULATIONS	INFORMATION GENERALLY TO BE REPORTED	ENTITIES GENERALLY COVERED BY STATUTE
Kansas	*Program* Data Analytic Interface (DAI) *Agency* Kansas Health Data Consortium/ Division of Health Care Finance (DHCF) (with support from the Kansas Insurance Department)	*Year Statute Enacted* 2006 *Statute* Kan. Stat Ann § 65-6801, et seq (2006) *Rules & Regulations* N/A	Eligibility, medical and pharmacy claims	The statute generally provides for data submission by medical care facilities, health care providers, home health agencies, and third party payors K.S.A. § 65-6801 states that "self-funded employee health plans, shall file health care data with the Kansas health policy authority as prescribed by the authority." However, thus far, the database appears to only include government-provided health care data. See http://www.kdheks.gov/hcf/medicaid_reports/Health_Care_Market_Reports.html
Louisiana	*Organization* Louisiana Health Care Quality Forum	*Statute* N/A *Rules & Regulations*	Eligibility, medical and pharmacy claims	This is a voluntary program which allows for submission of data by providers, payers, purchasers and consumers

State Health Reporting Laws

Summary Table

STATE	NAME OF PROGRAM/ RESPONSIBLE STATE AGENCY	PRIMARY STATUTE/ RULES & REGULATIONS	INFORMATION GENERALLY TO BE REPORTED	ENTITIES GENERALLY COVERED BY STATUTE
Maine	*Program* Maine Health Care Claims Database *Agency* Maine Health Data Organization	*Year Statute Enacted* 2001 *Statute* Me Rev Stat Ann Tit 22 §§ 8701-8713 (2009) *Rules & Regulations* Code Me R § 90-590, Chs 120 and 243 (2011)	Eligibility, dental, medical, and pharmacy claims, health care service provider files *Information collected includes* Type of product, type of contract, subscriber/member number, social security number, name; date of birth, gender, address, diagnosis code; procedure code, revenue code, service date, service provider, billing provider, plan payments, member payment, date paid, etc	Data is generally collected from health care providers and payors Payors includes health insurer carriers, third party administrators, Medicare health plan sponsors, and pharmacy benefits manager However, "[a]n employer exempted from the applicability of 24-A M R.S.A., chapter 56-A under the federal Employee Retirement Income Security Act of 1974 [ERISA] is not considered a carrier " Code Me R. § 90-590, Ch 243 at Sec 1 C Providers and payors are generally required to submit data if they cover or treat more than 49 Maine residents for which claims are being paid in any one month

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Summary Table

STATE	NAME OF PROGRAM/ RESPONSIBLE STATE AGENCY	PRIMARY STATUTE/ RULES & REGULATIONS	INFORMATION GENERALLY TO BE REPORTED	ENTITIES GENERALLY COVERED BY STATUTE
Maryland	*Program* Maryland Health Care Commission Medical Care Data Base *Agency* Maryland Health Care Commission (MHCC)	*Year Statute Enacted* 2000 *Statute* Md Code Ann , Health § 19-132, et seq , (2011) *Rules & Regulations* Md Regs Code Tit 10 § 25 06 (2011)	Eligibility, medical and pharmacy claims *Information collected includes* Professional Services Data Report, Pharmacy Data Report; Provider Director Report, Institutional Services Data Report, Medical and Pharmacy Eligibility Report, Patient identifier, date of birth, gender, zip code, claim paid date, diagnosis code, coverage type, claim-related condition, service date; billed charge, allowed amount, reimbursement amount, deductible, date of enrollment, co-payment, plan liability	The statute generally applies to insurers, HMOs, PBMS, TPAs that manage health benefit plans on behalf of a self-insured employer, third party administrators of self-funded plans, Medicaid and Medicare "[T]he Executive Director shall designate the payers that are required to submit data reports based on the payer's premium volume", however, this is "based on [premium] information reported by the payer to the Maryland Health Care Commission." COMAR 10 25 06 01 and 03(A)

State Health Reporting Laws

Summary Table

STATE	NAME OF PROGRAM/ RESPONSIBLE STATE AGENCY	PRIMARY STATUTE/ RULES & REGULATIONS	INFORMATION GENERALLY TO BE REPORTED	ENTITIES GENERALLY COVERED BY STATUTE
Massachusetts	*Program* All-Payer Claims Database *Agency* Massachusetts DHHS, Division of Health Care Finance and Policy	*Year Statute Enacted* 2010 *Statute* Mass Gen. Laws Ch. 118G §§ 6-6A (2010) *Rules & Regulations* Mass Regs Code Tit 114 5, §§ 21-22	Eligibility, dental, medical, and pharmacy claims; collection of provider and production files *Information collected includes* Subscriber and member identifiers, race, ethnicity, language information, plan type, benefit codes, enrollment start and end dates; behavioral and mental health indicators, substance abuse indicators, chemical dependency indicators, prescription drug benefit indicators	Massachusetts law generally requires reporting by public or private health payors, including insurance carriers, HMOs, nonprofit hospitals, and medical service corporations However, the definition of "private health care payor" specifically includes "self-insured plan[s]" only "to the extent allowable under federal law governing health care provided by employers to employees " Mass Gen Laws Ch 118G § 1 In addition, entities that cover less than 1,000 State residents are generally not required to report
Minnesota	*Program* Minnesota Health Care Claims Reporting System *Agency* Minnesota Department of Health	*Year Statute Enacted* 2009 *Statute* Minn Stat § 62U 04 (2010) *Rules & Regulations* Minn R 4653 0100, et seq.	Eligibility, medical and pharmacy claims Required information includes· Insurance type, gender, date of birth, address, medical coverage, admitting diagnosis, procedure code, paid amount, etc	Minnesota law generally defines "data submitter" to mean "a health plan company or third-party administrator that paid a total of at least $3,000,000 in health care claims for covered individuals during the previous calendar year," and defines third-party administrator to include TPAs that administer self-insured plans *See* Minn. R 4653 0100 at subparts 8, 18

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Summary Table

STATE	NAME OF PROGRAM/ RESPONSIBLE STATE AGENCY	PRIMARY STATUTE/ RULES & REGULATIONS	INFORMATION GENERALLY TO BE REPORTED	ENTITIES GENERALLY COVERED BY STATUTE
New Hampshire	*Program* New Hampshire Comprehensive Health Care Information System *Agencies* Partnership between New Hampshire Insurance Department and New Hampshire Department of Health and Human Services	*Year Statute Enacted* 2001 *Statute* N H Rev Stat Ann § 420-G 11-a (2005) *Rules & Regulations* N H Code Admin R Ann Ins 400-A 15 and 420-G 14 (2009)	Dental, eligibility, medical and pharmacy claims	Reporting rules generally apply to entities subject to insurance laws and rules of the State, including HMOs, non-profit health services corporations, TPAs or other entities arranging for or providing health coverage Data must be submitted for all State residents and for all members who receive services under a policy issued in the State The New Hampshire regulation provides that "third party administrator[s] shall be responsible for submitting claims data on self-insured plans that [they] administer " Reg 4004 01(f) Third party payors that write less than $25,000 in insurance premiums in the State on an annual basis, and TPAs that administer health insurance plans covering fewer than 200 New Hampshire lives, are not required to comply with reporting requirements

State Health Reporting Laws

Summary Table

STATE	NAME OF PROGRAM/ RESPONSIBLE STATE AGENCY	PRIMARY STATUTE/ RULES & REGULATIONS	INFORMATION GENERALLY TO BE REPORTED	ENTITIES GENERALLY COVERED BY STATUTE
New York	*Program*: Name to be determined *Agency*: New York State Department of Health	*Year Statute Enacted*: 2001 *Statute*: N.Y. Pub. Health § 2816 *Rules & Regulations*:	Claims data related to inpatient, outpatient, emergency department, pharmacy, eligibility information, and other health care services.	Not specified; regulations forthcoming.
Oregon	*Program*: Oregon All Payer Claims *Agency*: Office for Oregon Health Policy and Research	*Year Statute Enacted*: 2009 *Statute*: Or. Rev. Stat. §§ 442.446; 442.464; 442.993 (2009) *Rules & Regulations*: Or. Admin. R. 409-025 (2010)	Medical claims, eligibility, medical provider, pharmacy claims, and control totals. *Required information includes*: Enrollment data; paid claims; denied claims; payer name; claim ID; member ID; claim status; diagnosis; allowed amount; payment; co-payment; deductible; reports, schedules, statistics, or other data relating to health care costs, prices, quality, utilization; and, data related to race, ethnicity, and primary language.	The statute generally defines "reporting entity" to mean insurers, health care service contractors, third party administrators, pharmacy benefit managers, and coordinated care organizations. *See* O.R.S. 442.464. For insurance carriers and TPAs, this includes health care claims data for self-insured plans. All insurance carriers and TPAs with calculated mean total lives of 5,000 or higher are mandatory reporters.

State Health Reporting Laws

Summary Table

STATE	NAME OF PROGRAM/ RESPONSIBLE STATE AGENCY	PRIMARY STATUTE/ RULES & REGULATIONS	INFORMATION GENERALLY TO BE REPORTED	ENTITIES GENERALLY COVERED BY STATUTE
Rhode Island	*Program*: Rhode Island All Payer Database *Agency*: Rhode Island Department of Health	*Year Statute Enacted*: 1998 R.I. Gen. Laws § 23-17.17 *Rules & Regulations*:	Data submission requirements will be included in forthcoming regulations. May include health insurance claims and enrollment information used by insurers, information related to hospital finance, and any other information related to health care costs, prices, quality, utilization, or resources as required by the director.	The statute will generally require reporting by "insurers, health care providers, health care facilities and governmental agencies" to the extent "determined by the director to be necessary to carry out the purposes of this chapter." § 23-17.17-10(a). The term "insurer" is defined to mean "any entity subject to the insurance laws and regulations of this state." § 23-17.17-2(f).
Tennessee	*Program*: Tennessee All Payer Claims Database *Agency*: Department of Finance and Administration, Division of Health Planning	*Year Statute Enacted*: 2009 *Statute*: Tenn. Code. Ann. § 56-2-125 (2011) *Rules & Regulations*: Tenn. Comp. R. & Regs. §§ 0780-01-79-.01 through §§ 0780-01-79-.07	Member eligibility, medical claims, and pharmacy claims files. *Required information includes*: Type of insurance; coverage type; gender; date of birth; address; payer claim control number; paid date; admission date; discharge hour; discharge status; service provider number; admitting diagnosis; quantity of service provided; copay amount; drug code; etc.	Tennessee law generally requires reporting by all group health plans and health insurance issuers. *See* Tenn. Code Ann. § 56-2-125(f)(1)(A). "Group health plans" are defined as "employee welfare benefit plan[s]" identified in Section 3(1) of ERISA, but the definition excludes "any plan that is offered through a health insurance issuer." Tenn. Code Ann. § 56-2-125(a)(4). Health insurance issuers that paid less than $5 million for covered residents of Tennessee during the previous calendar year are not required to submit health care claims data set.

Summary Table

STATE	NAME OF PROGRAM/ RESPONSIBLE STATE AGENCY	PRIMARY STATUTE/ RULES & REGULATIONS	INFORMATION GENERALLY TO BE REPORTED	ENTITIES GENERALLY COVERED BY STATUTE
Utah	*Program*: Utah All Payer Claims Database *Agency*: Utah Department of Office of Health Care Statistics	*Year Statute Enacted*: 2007 *Statute*: Utah Code Ann. § 26-33a-104, et. seq. (2011) *Rules & Regulations*:	Enrollment, medical claims, and pharmacy data where Utah is the patient's primary residence and the same for services provided out of state to Utah residents. *Required information includes*: Transaction code; member ID; social security number; address; date of birth; race; ethnicity; diagnosis; etc.	Utah law generally defines "data supplier" to mean any health care facility, health care provider, third-party payor, health maintenance organization, government department, or self-funded employer. Utah Code Ann. § 26-33a-102(3). An entity that covers more than 200 individual Utah residents is required to submit data.
Washington	*Program*: Washington All Payer Claims Database (a non-state administered system) *Organization*: Puget Sound Health Alliance	*Statute*: N/A *Rules & Regulations*:	Eligibility, medical and pharmacy claims.	A voluntary program that includes various health purchasers and other entities.

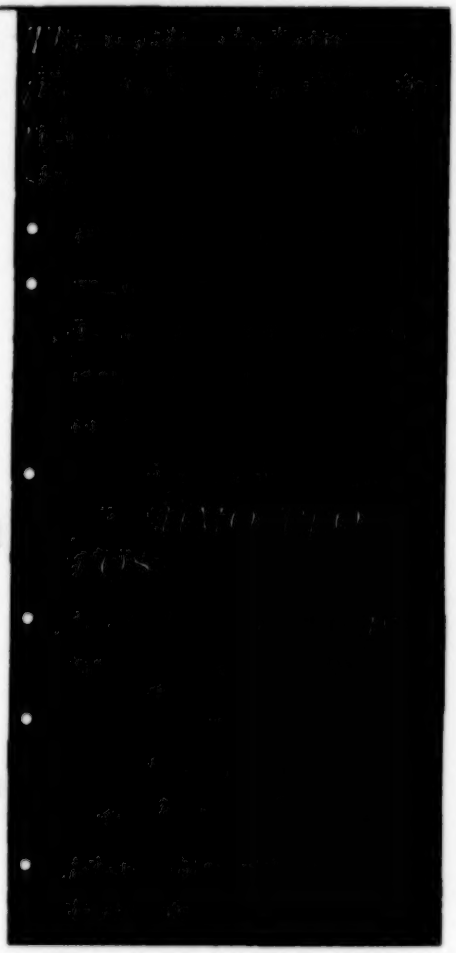
State Health Reporting Laws

Summary Table

STATE	NAME OF PROGRAM/ RESPONSIBLE STATE AGENCY	PRIMARY STATUTE/ RULES & REGULATIONS	INFORMATION GENERALLY TO BE REPORTED	ENTITIES GENERALLY COVERED BY STATUTE
West Virginia	*Program*: West Virginia Health Care Authority Database *Agency*: West Virginia Health Care Authority	*Year Statute Enacted*: 2011 *Statute*: W. Va. Code § 33-4A-1, et. seq., (2011) *Rules & Regulations*:	Enrollment, eligibility, medical claims data, and pharmacy claims data.	The statute generally provides for reporting by any entity that pays or administers the payment of health insurance claims or medical claims under workers' compensation insurance, including "any third-party administrator . . . that administers a fully-funded or self-funded plan." W. Va. Code § 33-4A-1(e). Health care payers that paid or administered the payment of health insurance claims on fewer than 500 covered lives in the previous calendar year are exempt.
Wisconsin	*Program*: The WHIO Health Analytics Exchange (a non-state administered system) *Organization*: Wisconsin Health Information Organization (WHIO), a private nonprofit organization.	*Year Statute Enacted*: 2009 *Statute*: Wis. Stat. § 153.80, et. seq., (2019) [sic] *Rules & Regulations*:	Eligibility, medical and pharmacy claims.	A voluntary program whose members include various health insurance companies and other entities.

What are All-Payer Claims Databases?

In the context of the current national dialog about health care and reform, states are trying to better understand and control healthcare costs and utilization. Over the past five years, at least twelve (12) states have enacted legislation and/or started to collect healthcare claims data from commercial and public payers in an effort to establish all-payer claims databases (APCDs). These data are being analyzed to understand patterns and trends of healthcare use and costs.



These databases hold the potential for a much deeper understanding of quality and cost of care across populations. The source of the data is from healthcare billing systems that process claims for private and public payers. In addition, some states are developing methods to capture data for uninsured individuals.

While the contents of individual states' APCDs vary, they typically include data from member eligibility files, provider files, medical and pharmacy claims files, and in a few states, dental claims files. The medical claims files include healthcare related data elements such as diagnosis codes, types of care received (procedure and pharmacy codes), insurance product type (HMO, PPO, POS), facility type (hospital, office, clinic), "cost" amounts (charge, paid, member liabilities), and provider information.

APCDs are being constructed and used for various research and policy purposes, from public health to health services and public policy research, consumer tools, employer coalition reporting, and payer and provider negotiation. For example, in New Hampshire, claims data have been used to better understand the distribution of health insurance coverage. Massachusetts has used the data to develop a public portal for pricing and quality information. Vermont has conducted a tri-state study of use of care in the Northern New England area. Minnesota will be using APCD data for development of provider peer grouping analysis (a method to compare providers based on a combination of cost and quality measures)[i]. Beyond public policy efforts, APCDs are being used by employer coalitions, insurers, providers, think tanks, and consumer groups. More examples can be found in the APCD Fact Sheet (available at www.apcdcouncil.org)[ii]

Why data collection standardization?

While APCDs represent a great opportunity to advance the understanding of cost, utilization, and quality of healthcare, currently each state is collecting different data by different methods and with different definitions. This non-uniform approach to developing APCDs is limiting the ability to share analysis and applications across states, and is raising costs for payers submitting data to the states (especially those payers that are operating in multiple states).

Standardization of data collection would ensure that states collecting the same data would do so in the same manner. A standardized data file submission would use an identical file structure (i.e., data element positioning and field lengths) in each state's database, but would not require that every state collect data for each element. Also, because individual states will likely want to have some data elements that are unique, processes for modifying the standard file structure to include additional data elements will need to be developed.

There has been some effort in the New England area to harmonize data collection efforts among Maine, New Hampshire, and Vermont. The initial rationale for this work towards standardization was to support regional-level analysis for these states that share borders and have cross-state use of the healthcare system. The harmonization of the data supported a

tri-state comparative study of healthcare cost and utilization across these three states, for example[iii]. As another example of the utility of standardization, the similarity of the data elements in Maine and New Hampshire allowed Maine to adopt the New Hampshire HealthCost[iv] methodology to efficiently create a similar web application[v] for Maine's APCD data.

What does it take for payers to provide this data?

As APCDs are required in more states, the cost to payers will become significant. APCD stakeholders have a common interest in reducing administrative costs associated with health care, and working together to establish an efficient, cost-effective APCD process should be a common goal. Because payers each use unique systems to administer their business, the challenges for payers to provide the required data vary. In general, a state will be more successful in collecting data elements if payers need those data elements to conduct their core business (versus situations in which states request data elements in the APCD that are not normally collected by insurance carriers). For example, payers have data needed to pay a provider, because claim payment is a core business function. Payers are less likely to know whether a provider has electronic medical records, for example, because that is unrelated to a core business function. Stakeholders should consider the relative costs and benefits of including a particular data

element in the APCD if payers do not ordinarily collect it. This can be done through engagement of industry partners to determine the business case for collection of additional data elements. Where feasible, the data elements and value sets proposed should be derived from existing and accepted data standards. For example, for the collection of patient language, International Organization for Standardization has several existing value code sets (e.g. ISO 639-2, 639-3).

Payers need a minimum of nine months to make systems changes and program the initial APCD data sets, and they recommend limiting changes to once a year, with six months advance notice. This allows payers to allocate programming resources and funding and creates a predictable schedule for all parties. Having standardized data elements, a predictable schedule with sufficient lead time for changes, and an ongoing collaborative process with all stakeholders on which data elements are required will support an efficient, cost effective APCD.

How can standardization of APCD data collection be achieved?

Existing Data Standards Maintenance Organizations (DSMOs), such as ANSI X12N (www.x12.org) and the National Council for Prescription Drug Programs (NCPDP, www.ncpdp.org), are responsible for developing and maintaining industry standards for insurance claims and eligibility files. These organizations have

formal processes for maintaining standards, including input, discussion, and publication. Many of the states that have developed APCDs reference the X12 standards in eligibility files and medical claims, and NCPDP standards in pharmacy claim files.

The Agency for Healthcare Research and Quality (AHRQ) has supported the APCD Council (www.apcdcouncil.org) to draft a core set of data elements for both the eligibility and medical files of APCD data submissions[vi]. The temporary core set of data elements is intended to foster harmonized data collection across states, and to start the process of developing a formal national standard for state-based APCD data submission. The process for creating the temporary core set of data elements for APCD includes three stages:

(1) Develop and vet a draft of a common core set of APCD data elements based on an inventory of the data elements for six APCDs from the states of Maine, New Hampshire, Vermont, Minnesota, Tennessee, and Massachusetts. (A draft of the state-by-state comparison and the details of the APCD elements can be found at: http://apcdcouncil.org/econometricaagency-healthcare-research-and-quality-ahrq)

(2) Vet draft recommendations with a larger group of other relevant national and local organizations in order to build consensus to harmonize data collection

(3) Engage the relevant DSMOs in the standards development

Similar pharmacy data standards work is being coordinated by the National Council for Prescription Drug Programs (NCPDP). Future work will need to occur with dental claims and provider index files.

The United States Health Information Knowledgebase (USHIK; http://ushik.ahrq.gov) project has inventoried the data collected by several states, and has established a metadata registry that enables comparisons of data element collection standards across data organizations. This is especially useful for states who are considering developing an APCD, or states who wish to change their data collection rules.

Summary

Over a dozen states across the country have enacted legislation and/or started to collect healthcare claims data from commercial and public payers in an effort to establish all-payer claims databases (APCDs). The state APCD efforts have begun as a way to better understand healthcare costs, quality, and utilization. While APCDs represent a significant opportunity to advance the understanding of these issues, currently most states are collecting different data by different methods and with different definitions. This non-uniform approach will limit the ability to share analysis across states and has negative cost implications for the payers who are submitting the data.

Standardization of state APCD data collection would address these issues. With assistance from existing DSMOs (i.e., ANSI X12N, NCPDP, in collaboration with the Agency for Healthcare Research and Quality (AHRQ), the APCD Council (www.apcdcouncil.org) has begun efforts to draft a temporary core set of data elements for both eligibility and medical files of APCD data submissions. Though this draft is the first step in a process of standards development, it begins the process of developing a formal national standard for state-based APCD data submission. Working with NCPDP and ANSI X12, final data collections standards will be developed for state adoption.

There is a clear goal to ensure that standards are available in 2011 for adoption by states as they develop new legislation or modify existing legislation.

Fact sheet prepared by the All-Payer Claims Database (APCD) Council in collaboration with the National Association of Health Data Organizations (NAHDO). Lead authors, Ms. Amy Costello, Project Director with the New Hampshire Institute for Health Policy and Practice at the University of New Hampshire and Ms. Mary Taylor, Head of Regulatory Compliance with Aetna.

For More Information on APCD's visit the following sites:

All-Payer Claims Database Council: http://www.apcdcouncil.org/

National Association of Health Data Organizations: http://www.nando.org/

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[i] Minnesota Department of Health, *Provider Peer Grouping*, http://www.health.state.mn.us/healthreform/peer/index.html

[ii] APCD Council, *APCD Fact Sheet 2010*, http://www.apcdcouncil.org/sites/apcdcouncil.org/files/APCD%20Fact%20Sheet_FINAL_1.pdf

[iii] Onpoint Health Data, *Tri-State Variation in Health Services Utilization & Expenditures in Northern New England*. http://www. bishca.state.vt.us/sites/default/files/Act49-Tri-State-Commercial-Variation.pdf

[iv] NH Healthcost, http://www.nhhealthcost.org

[v] Maine HealthCost, *Procedure Payments for the Insured*, http://www.healthweb.maine.gov/claims/healthcost/procedure_pricing_insured.aspx

[vi] Dental files and provider index files are currently not being addressed in the first phase.

NAHDO
NATIONAL ASSOCIATION OF HEALTH DATA ORGANIZATION

APCD COUNCIL All-Payer Claims Database [LOGO] UNIVERSITY *of* NEW HAMPSHIRE

New Hampshire Institute for Health Policy and Practice

No. 14-181

In The
Supreme Court of the United States

ALFRED GOBEILLE, in his official capacity as chair of the Vermont Green Mountain Care Board,
Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,
Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

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August 28, 2015

QUESTION PRESENTED

Like many other States, Vermont has developed an all-payer database to support health care policy, regulation, and research. The law requires all public and private entities that pay for health care services provided to Vermont residents, including insurers, government programs, and third-party administrators, to transmit to the database certain claims data reflecting medical services and expenditures. The question presented is:

May Vermont apply its health care database law to the third-party administrator for a self-insured ERISA plan?

PARTIES TO THE PROCEEDING

Petitioner Alfred Gobeille, in his official capacity as Chair of the Green Mountain Care Board, has been substituted for Commissioner Susan Donegan, who was the appellee in the court of appeals. *See* Supreme Court R. 35.3. Chair Gobeille has been substituted because the Vermont Legislature shifted responsibility for the unified health care database to the Green Mountain Care Board, effective June 7, 2013. *See* 2013 Vt. Acts & Resolves, No. 79, § 40. The original defendant in the district court was Commissioner Stephen Kimbell. Commissioner Donegan was substituted as a party when she replaced Commissioner Kimbell in office.

The respondent, Liberty Mutual Insurance Company, was the appellant in the court of appeals and the plaintiff in the district court.

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INTRODUCTION

To carry out their traditional roles as the primary regulators of public health, States need comprehensive, high-quality information about health care services and the health care market. Vermont's health care data-collection program advances the State's paramount interest in the health, safety, and welfare of its citizens. Building on data-collection programs that date back decades, Vermont and many other States—often with federal support—have developed comprehensive databases to track the health care services that are provided to their residents and the cost of those services.

All insurers generate such data, which afford a full and accurate picture of health care spending and utilization. Vermont collects data from all payers of health services provided to Vermont residents, including health insurers and public benefit programs. These "claims data" are the data that insurers (and public programs like Medicaid) generate in the normal course of business, as they compensate health care providers for their services. Collected and analyzed, this information yields powerful insights about quality of care, cost, and accessibility.

The Second Circuit erroneously interpreted the Employee Retirement Income Security Act of 1974 (ERISA) in holding that Vermont's law is preempted as applied to self-insured plans. That holding is especially anomalous because Liberty Mutual's third-party administrator is a health insurer that already collects and reports claims data for itself and for other self-insured ERISA plans that it administers.

The Second Circuit's holding runs afoul of this Court's conclusion two decades ago that ERISA was not intended to displace the States' authority over

"general health care regulation." *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995). Vermont's health care database statute has nothing to do with the purposes of ERISA and does not regulate the financing of the plan, the benefits offered, or the relationship between the plan and its members. It says nothing about how a plan must be structured and gives the State no authority to oversee its administration. Accordingly, ERISA does not preempt this Vermont statute.

OPINIONS BELOW

The opinion of the court of appeals (App. 1-47) is reported at 746 F.3d 497. The memorandum opinion and order of the district court (App. 48-80) is not reported, but is available at 2012 WL 5471225.

JURISDICTION

The judgment of the court of appeals was entered on February 4, 2014. A petition for rehearing was denied on May 16, 2014. App. 81-82. The certiorari petition was filed on August 13, 2014, and granted on June 29, 2015 (135 S. Ct. 2887). The jurisdiction of this Court rests on 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the U.S. Constitution provides:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing

in the Constitution or Laws of any State to the Contrary notwithstanding.

U.S. Const. art. VI, cl. 2.

The "other laws" provision of ERISA, 29 U.S.C. § 1144, is set forth at App. 83-90.

Vermont's health care database statute, Vt. Stat. Ann. tit. 18, § 9410, is set forth at App. 92-99. The Petition Appendix also includes the prior version of the statute, before a 2013 amendment that shifted responsibility for the database from the Vermont Department of Financial Regulation to the Green Mountain Care Board. App. 99-106.

The Regulation that governs the database, Regulation H-2008-01, is set forth at App. 107-41. The appendices to the Regulation (which provide data specifications and forms used for the database) are available online at http://gmcboard.vermont.gov/sites/gmcboard/files/REG_H-2008-01.pdf.

STATEMENT

I. Background

Building on longstanding efforts to collect health care data as a tool for improving public health—efforts that long predate ERISA—Vermont and many other States have created comprehensive health care databases.[1] Also known as an all-payer claims database, or APCD, Vermont's program collects information about the medical services provided to state residents, including the identity of the providers and the amount paid. Vermont uses these statewide utilization and spending data to improve the delivery of health care to Vermont residents and achieve better health care

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[1] At least 18 States have these databases in place or in development. *See* APCD Council, *Interactive State Map*, http://www.apcdcouncil.org/state/map.

outcomes; to develop strategies to control costs while improving quality of care; and to promote health care research. The State gathers this information by requiring health care payers, including insurers and third-party plan administrators, to pass along data they already have and generate in the ordinary course of business.

A. Vermont's history of health care data-collection and analysis

The States have long collected and analyzed information to promote the health of their residents. For well over a century, States have required doctors to report instances of infectious diseases. *See* 1900 Vt. Acts & Resolves No. 91, § 4; Ctrs. for Disease Control & Prevention, *Mandatory Reporting of Infectious Diseases by Clinicians*, 39 Morbidity and Mortality Weekly Report RR-9 (1990) (*Mandatory Reporting*).[2] Collecting data helps States contain the spread of disease and supports research aimed at better prevention and treatment programs. *See Mandatory Reporting*; *see also, e.g.*, Vt. Gen. Laws §§ 6099-6101 (1917) (directing board of health to maintain records of tuberculosis cases, "investigate the prevalence and extent" of the disease, and address education, prevention, and cure). Statistical research and data-collection efforts have supported state public health programs ranging from vaccination to combating drug abuse. *See, e.g.*, *Jacobsen v. Massachusetts*, 197 U.S. 11, 31 & n.+ (1905) (smallpox vaccination); *Whalen v. Roe*, 429 U.S. 589, 597-98 (1977) (drug abuse).

Other, broader efforts to compile public health data also predate ERISA and go back at least 50 years. In

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[2] *Available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/00001665.htm.

the early 1960s, researchers at the University of Vermont created one of the first statewide hospital data sets, consisting of patient discharge summaries submitted by Vermont hospitals. *See* Kerr L. White, *A Historical Look at Variations*, 24 Health Aff. 295 (2005); John E. Wennberg, *Tracking Medicine: A Researcher's Quest to Understand Health Care* 16 (2010). The program expanded to include census data, vital statistics, and Medicare claims records provided by Blue Cross/Blue Shield. *See generally* Wennberg, *Tracking Medicine* 3-6, 14-25. Beginning in 1972, the Cooperative Health Information Center of Vermont (CHICV) operated this database. *See* Coralea N. Lapenas, *CHICV's Role in Vermont Health Care* 1 (1979).[3]

Vermont's early data-collection efforts enabled groundbreaking research into the delivery of medical care in the State. A 1973 study revealed startling disparities in hospitalization and surgery rates across Vermont communities. *See* John Wennberg & Alan Gittlesohn, *Small Area Variations in Health Care Delivery*, 182 Sci. 1102 (1973); *see also* Wennberg, *Tracking Medicine* 18. As a result, physicians changed their practices to reduce unnecessary surgeries. *See* John E. Wennberg et al., *Changes in Tonsillectomy Rates Associated with Feedback and Review*, 59 Pediatrics 821 (1977). CHICV also "provide[d] reports to State and Federal Agencies, hospitals, the medical profession, and a variety of other data users." *CHICV's*

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[3] *Available at* http://www.ago.vermont.gov/assets/files/GCAI/CHICVs%20Role%20in%20Vermont%20Health%20Care.pdf. CHICV was a non-profit, "quasi-public" body whose board included, among others, a former governor and a federal judge. It received federal funds and later served the data-collection needs of several state agencies. *See CHICV's Role in Vermont Health Care* 2-10.

Role in Vermont Health Care 1; *see id.* at 21 (discussing uses of 1977 report on hospitalization data).

The federal government supported, funded, and at times mandated Vermont's health care data collection, both before and after ERISA was enacted. The compilation of the initial hospital discharge data set, its expansion, and the creation of CHICV were all undertaken with federal funds and pursuant to federal programs. *See* Wennberg, *Tracking Medicine* 14-17; *CHICV's Role in Vermont Health Care* 1-2, 6 & Figure 2. CHICV began in 1972 as a pilot "model health statistical center" under the Department of Health, Education and Welfare's cooperative health statistics program. *See CHICV's Role in Vermont Health Care* 6-7. That program was codified in 1974 by the same Congress that enacted ERISA. *See* Health Services Research, Health Statistics, and Medical Libraries Act of 1974, Pub. L. No. 93-353, 88 Stat. 362. This federal health statistics program sought to create a "coalition among the various levels of government—Federal, State, and local"—and provide for the "collection of any particular data element by the level of government that is best equipped to collect it." Edward B. Perrin, *The Cooperative Health Statistics System*, 89 Health Servs. Rep. 13 (1974).[4] CHICV evolved to serve the needs of Vermont's Professional Standards Review Organization and Health Systems Agency, both of which were subject to federal data-collection mandates.[5] *See CHICV's Role in Vermont Health Care*

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[4] *Available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1616237/.

[5] *See* Social Security Amendments of 1972, Pub. L. No. 92-603, § 249F, 86 Stat. 1329, 1429; National Health Planning and Resources Development Act of 1974 (NHPRDA), Pub. L. No. 93-641, §§ 1-3, 88 Stat. 2225, 2225-2257 (1975) (repealed in part

6-10 & Figure 2. Later, to comply with the Health Services Research, Health Statistics, and Health Care Technology Act of 1978, Pub. L. No. 95-623, § 5, 92 Stat. 3443, 3445, Vermont designated its Department of Health as the coordinating agency for health data activities. *See* Vt. Stat. Ann. tit. 3, app. exec. order 18-1 (No. 35-79 (1979)).

Although these early efforts achieved important successes, the available data were limited. Vermont's programs relied primarily on hospital discharge data. *See* Hamilton Davis, *Health Care, in Vermont State Government Since 1965*, at 384 (Michael Sherman ed., 1999).[6] But hospital data provide only a limited snapshot of health care services, even when combined with other information collected by CHICV. Vermont hospitals do not have records of treatment that Vermont residents receive elsewhere.[7] Care received outside the hospital setting, like doctors' visits and drugs prescribed, is not included. And, critically, those records do not allow researchers to track the care received by the same patient from different providers.[8] Contemporaneous federal and state reports acknowledged a

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1986); *see also Travelers*, 514 U.S. at 665 (noting that NHPRDA "provided for the organization and partial funding of regional 'health systems agencies' responsible for gathering data").

[6] Vermont continues to collect hospital discharge data pursuant to Vt. Stat. Ann. tit. 18, §§ 9410, 9456, and 9457

[7] Not surprisingly for a small State, Vermonters often receive out-of-state hospital care. *See* Michael Davis & Lori Perry, *2013 Vermont Health Care Expenditure Analysis: Legislative Version* 29 (2015) (about 20% of hospital discharges for Vermont residents in 2012 were from out-of-state hospitals), *available at* http://gmcboard.vermont.gov/sites/gmcboard/files/2013EA_includes_provider_FINAL_leg_short%20%282%29.pdf.

[8] As explained below, VHCURES complies with the federal Health Insurance Portability and Accountability Act of 1996

need for better information. *See, e.g., Final Report of the Governor's Commission on Medical Care* 3, 8 (1974) (noting that, although CHICV's data were "of invaluable assistance," there remained a dearth of "reliable current data necessary to plan and monitor the State's health care program"); Jennifer Robbins, *The Use of Population-Based Data for Rate Setting, in* 6 Integration of Information for Hospital Rate Setting (HEW Pub. No. 77-11722 (1976)) (explaining that, even with hospital data, regulators were "forced to examine information on the use of medical care resources in light that is seriously dimmed" because "no one has data on the whole system on a statewide basis"); Vt. Stat. Ann. tit. 3, app. exec. order 18-1 (No. 35-79 (1979)) (recognizing problem of "inadequate information" and need for health care data).

B. The Vermont all-payer database

As health care costs escalated, the demand for better information also grew. A 1992 Vermont report noted that it was impossible to accurately predict the consequences of proposed policies because the State lacked "the necessary data or analytical capability." *Final Report of the Vermont Blue Ribbon Commission on Health* 7-8 (1992). The report recommended new information-gathering tools to "develop the utilization and reimbursement data necessary for further planning design and management." *Id.* at 3. The Vermont Legislature accordingly directed a new state Health Care Authority to "establish and maintain a unified health care data base," which should reflect "all health

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(HIPAA), and patient identifying information is encrypted. *See infra* p. 11.

care utilization, costs and resources" in the State. 1992 Vt. Acts & Resolves No. 160, § 1.

That statute marked the beginning of Vermont's all-payer claims database. Initial attempts to rely on voluntary participation by major insurers did not succeed. Meanwhile, Maine and New Hampshire began building all-payer databases by mandating that insurers in those States report their spending data. *See* Me. Rev. Stat. tit. 22, § 8704; N.H. Rev. Stat. Ann. § 420-G:11-a; Patrick Miller et al., *All-Payer Claims Databases: An Overview for Policymakers* 4 (2010). In 2005, the Vermont Legislature took a similar approach and required health insurers to provide data on paid claims that was encrypted and de-identified to protect patient privacy. 2005 Vt. Acts & Resolves No. 71, § 312. Vermont's all-payer claims database—now known as the Vermont Health Care Uniform Reporting and Evaluation System or VHCURES—became operational in 2009.

VHCURES is designed to inform the State's health care policy, including its over-arching aim "to ensure that all residents have access to quality health services at costs that are affordable." Vt. Stat. Ann. tit. 18, § 9401(a) (App. 91); *id.* § 9410(a)(1) (App. 92). The statute sets forth goals for VHCURES, including:

> (A) Determining the capacity and distribution of existing resources.
>
> (B) Identifying health care needs and informing health care policy.
>
> (C) Evaluating the effectiveness of intervention programs on improving patient outcomes.
>
> (D) Comparing costs between various treatment settings and approaches.

(E) Providing information to consumers and purchasers of health care.

(F) Improving the quality and affordability of patient health care and health care coverage.

Id. § 9410(a)(1) (App. 92).

VHCURES contains information supplied by health care "payers"—that is, government agencies, insurers, and similar entities that *pay* for health care services provided to Vermont residents. *Id.* § 9410(c), (h), (j) (App. 94-99). The statute requires health insurers to provide data on paid claims to the Board. *Id.* § 9410(h) (App. 95-96). The federal government voluntarily supplies Medicare claims data to VHCURES and has authorized Vermont to include data on Medicaid claims. *See* U.S. CVSG Br. 18; Pet. 22 n.3; *see also* 42 U.S.C. § 1395kk(e) (authorizing use of Medicare claims data "to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use").

To encompass all entities that pay for care provided to Vermont residents, the database statute defines "health insurer" to include "any third party administrator, any pharmacy benefit manager, any entity conducting administrative services for business, and any other similar entity with claims data, eligibility data, provider files, and other information relating to health care provided to Vermont resident[s]." Vt. Stat. Ann. tit. 18, § 9410(j)(1)(B) (App. 98). The implementing rule notes that the term "may also include, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities." Regulation H-2008-01, § 3(X) (App. 112-13). Only insurers with 200 or more covered members living in Vermont (or receiving covered services in

Vermont) must provide information to the database. *Id.* § 3(Ab) (App. 113).

State Regulation H-2008-01 (App. 107-41) supplies further details of database administration.[9] It sets forth "requirements for the submission of health care claims data, member eligibility data, and other information relating to health care provided to Vermont residents or by Vermont health care providers." *Id.* § 1 (App. 107). Only information about paid claims must be provided, not claims that are denied. *Id.* § 5(A)(8) (App. 121). The rule also does not require information about the benefits the health insurer provides or any other aspect of plan administration or financing.

The statute and rule protect personal privacy. The statute requires compliance with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), *see* Vt. Stat. Ann. tit. 18, § 9410(h)(2) (App. 96), and mandates that confidential information be "filed in a manner that does not disclose the identity of the protected person," *id.* § 9410(e) (App. 94-95). The regulation provides standards for encrypting information prior to submission, Reg. H-2008-01, § 5(A)(5) (App. 119-21), and prohibits submission of "direct personal identifiers," *id.* § 7(A)(5) (App. 128-29). And the law forbids public disclosure of such identifiers, including names, addresses, and Social Security numbers. Vt. Stat. Ann. tit. 18, § 9410(h)(3)(D) (App. 97-98). As the United States has explained, the Centers for Medicare and Medicaid Services (CMS) provide Medicare claims data "on the condition that

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[9] Regulation H-2008-01 was promulgated by the state agency that previously administered the database. The regulation remains in effect.

Vermont protect the privacy of the information." U.S. CVSG Br. 18 n.7.

C. Uses of VHCURES data

The State uses the VHCURES database to improve the delivery of medical care to its citizens and guide health care regulation and policy. Its usefulness is driven by two factors: that claims data are a readily available and accurate measure of health care utilization and spending; and that the database includes comprehensive *statewide* claims data. These databases are called "all-payer" because—building on earlier, more limited data sets—States sought to capture health care expenditures for as much of their population as possible. As of 2014, VHCURES included expenditures for more than 90% of the Vermont population. If VHCURES lost data from all self-insured plans, nearly 20% of that population would be excluded.[10] The database would be both less comprehensive and skewed, because private-sector workers covered by self-insured plans tend to be younger and healthier than the population as a whole. *See* New York et al. Cert. Amicus. Br. 7; *see also* U.S. CVSG Br. 22 (without data from self-insured plans, "databases will be significantly less comprehensive and thus not as useful").

1. The health care database is an invaluable public health tool, because it allows researchers to measure and compare not just cost, but utilization of

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[10] *See* Michael Davis & Lori Perry, *2013 Vermont Health Care Expenditure Analysis* 12 (2015), *available at* https://outside.vermont.gov/sov/webservices/Shared%20Documents/EA_includes_provider.pdf; Vermont Asthma Program, *The What, Who, Why, and How of All-Payer Claims Databases* 4 (2014), *available at* http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=14763&lid=3.

services and quality of care. The Vermont Department of Health uses VHCURES data in its public health programs. VHCURES is part of the Department's birth information network aimed at "preventing and controlling disease, injury, and disability." Vt. Stat. Ann. tit. 18, § 5087(b). The Department has also used the database to study the prevalence of asthma and the rate of emergency room visits and hospitalizations for asthma.[11]

Vermont's "Blueprint for Health" uses the database extensively. The Blueprint is "dedicated to achieving well-coordinated and seamless health services, with an emphasis on prevention and wellness, for all Vermonters." Dep't of Vt. Health Access, *Vermont Blueprint for Health Manual* 3 (2015); *see also* Vt. Stat. Ann. tit. 18, § 701(1). One of the Blueprint's key innovations is to provide enhanced payments—from Medicare, Medicaid, and the major commercial insurers—to participating providers that meet national quality standards. *See Blueprint for Health Manual* 6-13. The Blueprint relies on VHCURES to measure the program's success. *See, e.g.*, Vt. Blueprint for Health, *2011 Annual Report* 19 (2012). VHCURES data have shown, for example, not only that payments under the program have been offset by lower health care expenditures, but also that patients being treated by participating providers received more effective preventive care. *See* Vt. Blueprint for Health, *2014 Annual Report* 15-18 (2015); Vt. Blueprint for Health, *2013 Annual Report* 11 (2014). VHCURES also enables the Blueprint to provide regular profiles for service

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[11] Vt. Dep't of Health, *Burden of Asthma among the Medicaid Insured in Vermont* (2014), *available at* http://healthvermont.gov/research/asthma/documents/asthmamedicaidbrief_2014_10.pdf.

areas and individual practices "with comparative results for a set of standardized expenditure, utilization, and quality measures." Steven Thompson et al., *Evaluating Health Care Delivery Reform Initiatives in the Face of "Cost Disease,"* 18 Population Health Mgmt. 6, 7 (2015). These profiles give providers "data to assist in honing their quality improvement efforts." *2014 Annual Report* at 53, 83-84. The Blueprint plans to use these profiles to provide additional financial incentives for providers that coordinate care with their community partners and improve patient outcomes for their entire service area. *See id.* at 33-34.[12]

Outside researchers also use VHCURES data to study public health. The Dartmouth Atlas Project published a comprehensive report that documented "marked variation" in pediatric health care across Maine, New Hampshire, and Vermont—all States with APCDs. David Goodman et al., *The Dartmouth Atlas of Children's Health Care in Northern New England* 3 (2013). That report emphasizes the importance of all-payer claims databases "for understanding children's health care" because there are no alternative sources and, as a result, "pediatric health care often occurs within a black box where the type, quantity, and outcomes of care are unknown." *Id.* at 6-7. Researchers found significant differences by geography and type of insurer in the rate of drugs prescribed to children in New England. *See* Shelsey J. Weinstein et al., *Small Geographic Area Variations in Prescription Drug Use*, 134 Pediatrics 563, 566 (2014). And researchers also have used the data to investigate and document increases and variations in health care

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[12] The Blueprint was selected by the Centers for Medicare and Medicaid Services to participate in CMS's patient-centered medical home demonstration. *See 2011 Annual Report* at 31.

spending across the region. *See* Carrie H. Colla et al., *Tracking Spending Among Commercially Insured Beneficiaries Using a Distributed Data Model*, 20 Am. J. Managed Care 650 (2014).

2. The Green Mountain Care Board, which oversees key aspects of Vermont's health care system, routinely uses the database for its regulatory responsibilities. The Board approves health insurance rates, Vt. Stat. Ann. tit. 18, § 9375(b)(6), and relies in part on VHCURES data to evaluate whether rates are affordable and promote quality and access to care, *id.* tit. 8, § 4062(a)(3). The Board also reviews hospital budgets, *id.* tit. 18, § 9375(b)(7), and similarly uses the comprehensive VHCURES data to review utilization and expenditure assumptions in that process, *id.* § 9456(b). For example, all-payer data enable the Board to analyze the so-called "cost shift," that is, "the extent to which costs incurred . . . in connection with services provided to Medicaid beneficiaries are being charged to non-Medicaid health benefit plans and other non-Medicaid payers." *Id.* § 9456(b)(8).

3. Controlling the growth of health care costs is one of the most pressing issues facing state governments. VHCURES delivers data needed to understand how and why health care costs are rising. Vermont's goal is to provide its residents "access to quality health services at costs that are affordable." Vt. Stat. Ann. tit. 18, § 9401 (App. 91); *see also id.* § 9410 (App. 92) (directing Board to improve the health of Vermont residents and reduce the growth of health care costs while protecting access to health care and quality of care). Rising costs are not just a budget problem, but also a public health problem. Board-directed researchers have used VHCURES data to examine variations in health care pricing in the State.

See Michael Del Trecco et al., *Vermont Health Systems Payment Variation Report* 1 (2013) (finding "significant variation" between payers and hospitals and also "within the same hospital, same payer setting"). Researchers are also comparing growth in spending for commercial insurers and Medicaid, and looking at whether cost increases are driven by prices or utilization. *See, e.g.*, Truven Health Analytics & Brandeis Univ., *Vermont Health Spending Growth Drivers Commercial and Medicaid, 2008-2012: Presentation to the Green Mountain Care Board* (2015).[13]

Finally, the Vermont Legislature has directed the Board to pursue a data-driven approach to containing health care spending while improving the quality and efficacy of the care provided. The Board oversees payment reform pilot projects—that is, innovative approaches that seek to align payment with patient outcomes, provide incentives for controlling costs, and support coordinated, evidence-based treatment. *See generally* Vt. Stat. Ann. tit. 18 §§ 9375(b)(1), 9377. The Board must oversee and evaluate these initiatives, a task that relies on VHCURES's comprehensive picture of Vermont's health care landscape.

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[13] *See also* Univ. of Vt. Coll. of Med. et al., *Price Variation Analysis* (2014); Health Care Cost Inst., *2007-2011 Vermont Health Care Cost and Utilization Report* (2014); Vt. Dep't of Fin. Regulation, *Spatial Analysis Study: Development of Primary Care Service Areas* (2013); Onpoint Health Data, *Tri-State Variation in Health Services Utilization & Expenditures in Northern New England* (2010), all available at http://www.gmcboard.vermont.gov/VHCURES/Analytics_and_Reports.

D. ERISA's reporting requirements

Congress enacted ERISA "to protect . . . the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b). The statute requires plans to be established and maintained pursuant to a written instrument and to have named fiduciaries with authority to control and manage the administration of the plan and its assets. *Id.* §§ 1102(a)(1), 1103(a).

ERISA's reporting, disclosure, and fiduciary duty requirements "insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator." *Calif. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 327 (1997) (citation omitted). Plan administrators must annually file detailed financial and actuarial information with the Secretary of Labor, and must file additional reports with the Secretary when a plan winds up its affairs or when an employer fails to make a payment required under ERISA's minimum funding standard. *See* 29 U.S.C. §§ 1021-1025. Health insurance and other welfare plans, however, generally are exempted from most of ERISA's reporting requirements. *See* 29 C.F.R. §§ 2520.103-1, 2520.104-20, 2520.104-44; *see also* 29 U.S.C. § 1024(a)(3); U.S. CVSG Br. 2.

With certain exceptions, ERISA preempts "any and all State laws insofar as they . . . relate to any employee benefit plan" covered by the statute. 29 U.S.C.

§ 1144(a). This Court, recognizing the "frustrating difficulty" of construing the term "relate to," *see Travelers*, 514 U.S. at 656, has rejected a "strictly literal reading" of ERISA's preemption clause. *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813 (1997). The Court instead looks to "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Travelers*, 514 U.S. at 656.

II. Procedural History

A. District court proceedings

Respondent Liberty Mutual filed this suit to block Vermont from obtaining claims data for its employee health plan. Liberty Mutual, an insurance company based in Massachusetts, provides health care for about 80,000 employees, retirees, and their families through a self-funded plan governed by ERISA. Liberty Mutual is the "named fiduciary" and "plan administrator" for ERISA purposes. App. 7-8, 50.

Liberty Mutual contracts with a third-party administrator, Blue Cross Blue Shield of Massachusetts, to administer the plan. App. 8, 50-51. Blue Cross "processes medical claims . . . , receives participants' confidential medical records and generates claims data." App. 50-51. Blue Cross is a mandated reporter for Vermont's database, because Blue Cross provides or administers benefits for several thousand Vermonters, including the 137 members of Liberty Mutual's plan who live in Vermont. App. 7-8, 50; JA205. Because of its small number of Vermont participants, Liberty Mutual itself is not required to provide information for Vermont's database. App. 8, 58.

In 2010, Blue Cross provided claims data for 7,605 individuals to VHCURES, including 3,667 members of self-insured plans. JA205; *see* App. 72-73 n.5. In 2011,

after learning that Liberty Mutual had instructed Blue Cross not to report data to VHCURES for Liberty Mutual's Vermont participants, the Department of Financial Regulation (previously responsible for the database) subpoenaed the information from Blue Cross. JA30-33. Liberty Mutual refused to allow Blue Cross to report information for its Vermont beneficiaries. App. 9, 56.

Liberty Mutual then filed this lawsuit, claiming that ERISA preempts any requirement that its third-party administrator (Blue Cross) provide information to Vermont's health care database. JA12-29. The State moved to dismiss; Liberty Mutual moved for summary judgment. App. 9, 49. With the agreement of the parties, the district court treated the motions as cross-motions for summary judgment. *Id.* In a written decision, the court rejected Liberty Mutual's preemption claim and granted judgment to the State. App. 48-80.

In ruling for the State on Liberty Mutual's claim of preemption, the district court first held that the database statute does not have a "reference" to ERISA plans. App. 69. As the court explained, the law requires numerous entities, including insurers and providers, to supply information to the database. *Id.* Therefore, "Vermont's statute and regulation do not act immediately and exclusively upon ERISA plans, nor is the existence of ERISA plans essential to their operation." *Id.*

Second, the district court concluded that the database statute does not have an impermissible "connection with" an ERISA plan. App. 69-78. After surveying this Court's decisions and relevant circuit precedent, the court emphasized that Vermont's law: (i) did not "attempt to control, supersede or interfere with the operation of an ERISA plan"; (ii) "has no

effect whatsoever on the core relationships that ERISA was designed to protect—those between participants, beneficiaries, administrators and employers"; and (iii) has "no effect whatsoever on the core ERISA functions—such as processing claims or disbursing benefits." App. 79.

The district court recognized that even a generally applicable law might be preempted if it "creates an economic effect so acute as to dictate certain administrative choices." App. 72. Here, however, Liberty Mutual had no reporting obligations at all, and there was "no evidence" that its third-party administrator, Blue Cross, was "laboring under any sort of burden" in complying with the law. App. 72 n.5. Indeed, Blue Cross provided information to VHCURES for other ERISA plans. App. 73 n.5. Liberty Mutual did "not submit[] any information about any actual burden suffered by itself or [Blue Cross] in producing this information." *Id.*

B. Second Circuit decision

On appeal, a divided Second Circuit reversed. App. 1-47. While agreeing with the district court that Vermont's statute and regulation "lack 'reference to' an ERISA plan," App. 23 n.9, the majority held that Vermont's law has an impermissible "connection with" ERISA plans, App. 23. The court viewed "reporting" as a core ERISA concern that is undermined by any state requirement for "plan record-keeping, and filing with a third party," and emphasized that Vermont's database "is called the 'Vermont Healthcare Claims Uniform *Reporting* and Evaluation System.'" App. 23-24. The court, moreover, concluded that "health

data collection" is not among "the states' historic police powers." App. 18 n.8.

The Second Circuit concluded further that only a "slight reporting burden" on self-insured plans would be permissible under ERISA. App. 24. The majority saw Vermont's "scheme" as "obviously intolerable," describing the claims data reporting requirements as "burdensome, time-consuming, and risky." App. 25. The court reasoned that any "burdens and risks must be multiplied" because of unspecified reporting requirements in other States. App. 29. The court described Vermont's detailed confidentiality provisions as "complex but loose" and suggested that the regulation was problematic because it could be changed in the future. App. 27-28.

Based on this reasoning, the majority held Vermont's law preempted. App. 23-29.

Judge Straub dissented. App. 30-47. He maintained that Vermont's health care database is "wholly distinct" from ERISA's reporting requirements and seeks "after-the-fact information which plan administrators . . . already have in their possession." App. 38, 39. Judge Straub agreed with the Department of Labor's position that "the focus and purpose of Vermont's data collection is different from the reporting requirements in ERISA." App. 38. As he found, the "Vermont statute regulates health care within that state, while imposing a purely clerical burden on ERISA plans." App. 46. The law "does not hinder the national administration of employment benefit plans" or require any "distinction in benefits between Vermont and any other state." App. 44. For Judge Straub, that "end[ed] the inquiry." *Id.*

Judge Straub also criticized the majority for failing to apply the presumption against preemption. App.

33-34. He noted further that the majority's description of Vermont's reporting requirement as "time-consuming and risky" was "pure speculation" because there was "no evidence to support such a finding." App. 46.

SUMMARY OF ARGUMENT

I. This Court's precedents provide no basis for finding preemption in this case. ERISA governs the financial solvency of employee benefit plans, the conduct of plan fiduciaries, and the content and performance of the promise to pay benefits to employees. As this Court has consistently recognized, however, ERISA leaves undisturbed "myriad" state laws and regulations that have some effect on ERISA plans, but do not regulate their terms or otherwise undermine ERISA's core objectives. *See, e.g.*, *De Buono*, 520 U.S. at 815; *Dillingham*, 519 U.S. at 334; *Travelers*, 514 U.S. at 661, 668. In particular, Congress did not intend ERISA to supplant the States' traditional responsibility for "general health care regulation." *Travelers*, 514 U.S. at 661.

Vermont's statute concerns health care, not benefit plans. Vermont's database statute serves traditional public health and regulatory purposes. Not only have States long relied on data collection for public health purposes, but also the federal government has financially supported and relied on these state programs. There is no reason to conclude that Congress intended ERISA to preempt a state statute that gathers information on payments for health care for public health purposes, and does not address—indeed, is indifferent to—the manner in which ERISA plans are administered.

The relevant question is not, as the Second Circuit suggested, whether ERISA is concerned with plan

reporting and disclosures to participants. It is. *See, e.g.*, *Travelers*, 514 U.S. at 661. The relevant inquiry is whether Vermont's effort to collect comprehensive statewide data about health care spending and services interferes with any of ERISA's core objectives. It does not. The state law merely requires Blue Cross—Liberty Mutual's third-party administrator—to transmit certain claims data it generates as a matter of course. There is no meaningful difference between Vermont's statute and other generally applicable state laws that this Court has upheld against ERISA challenges.

II. The Second Circuit's conclusion that providing claims data is burdensome and threatens patient confidentiality has no support in the record and should be disregarded. As both the district court and the dissenting judge below recognized, Liberty Mutual supplied no evidence that its third-party administrator was "laboring under any sort of burden" in supplying the data. App. 72 n.5; App. 39 (Straub, J., dissenting). The third-party administrator, Blue Cross Blue Shield of Massachusetts, has the claims data and provides them to Vermont for itself and other ERISA plans for which it serves as the third-party administrator. And any suggestion that the database program threatens patient confidentiality is unfounded. Personal identifying information is encrypted, and the program complies with HIPAA's privacy requirements. Indeed, the federal government provides Medicare claims data "on the condition that Vermont protect the privacy of the information." U.S. CVSG Br. 18 n.7.

ARGUMENT

I. Applying established principles for ERISA preemption, Vermont's health care database law is not preempted.

This Court repeatedly has rejected a "strictly literal reading" of ERISA's preemption clause, which preempts "any and all State laws insofar as they . . . relate to any employee benefit plan" covered by the statute. *De Buono*, 520 U.S. at 812-13; 29 U.S.C. § 1144; *see also Travelers*, 514 U.S. at 655-56. Initially construing that preemption provision, the Court observed that a "law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 96-97 (1983). In *Travelers*, however, the Court cautioned against "uncritical literalism" in construing either "relates to" in the statute or the "connection with" gloss in *Shaw*. *Travelers*, 514 U.S. at 656. Neither "infinite relations" nor "infinite connections" can be the "measure of pre-emption." *Id.*[14]

In *Travelers*, the Court re-focused the preemption analysis on Congress's intent in passing ERISA. There and in subsequent decisions, the Court has looked "to the objectives of the ERISA statute as a guide to the scope of the state law that Congress

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[14] The "reference to" prong of the two-part *Shaw* test is not at issue in this case. The Second Circuit correctly held that the "Vermont statute and regulation lack 'reference to' an ERISA plan because they apply to all health care payers and do not act 'exclusively upon ERISA plans.'" App. 23 (quoting *Dillingham*, 519 U.S. at 325). Liberty Mutual did not argue otherwise below or contest this point in its opposition to the petition for certiorari. *See* Opp. 14 (defending Second Circuit's application of "connection with" test); Liberty Mutual C.A. Br. 20 (relying on "connection with" prong).

understood would survive." *Id.*; *Dillingham*, 519 U.S. at 325; *De Buono*, 520 U.S. at 813-14. This precedent establishes that ERISA does not override "general health care regulation" or otherwise displace traditional state regulation in areas where "ERISA has nothing to say." *Travelers*, 514 U.S. at 661; *Dillingham*, 519 U.S. at 330. The balance Congress struck in ERISA leaves ample room for generally applicable state laws that govern health care, including Vermont's health care database statute.

A. ERISA does not preempt generally applicable state health care regulations that neither mandate particular employee benefits nor interfere with plan administration.

As this Court has explained, ERISA does not supplant the States' traditional role in regulating health care. *See De Buono*, 520 U.S. at 814-16; *Travelers*, 514 U.S. at 654-55. Those cases upheld generally applicable state health care laws, despite financial and regulatory burdens on ERISA plans. *Travelers* and *De Buono* establish two fundamental principles that control the outcome of this case: first, the preemption inquiry is measured by Congress's objectives in enacting ERISA; and, second, Congress did not intend ERISA to displace generally applicable state health care regulations.

1. The scope of ERISA's preemption language is guided by the "objectives of the ERISA statute." *Travelers*, 514 U.S. at 656. *Travelers* and the Court's subsequent rulings in *Dillingham* and *De Buono* require courts to analyze not the potential breadth of the phrase "relate to," but rather the "type of state law that Congress intended ERISA to supersede." *De Buono*, 520 U.S. at 814.

Three core objectives of ERISA bear on the scope of preemption: (i) ensuring that plans act as fiduciaries and provide the benefits promised to plan beneficiaries; (ii) providing an exclusive mechanism to enforce ERISA's protections; and (iii) establishing a uniform body of law to govern the provision and funding of benefits.

First, ERISA was intended to protect beneficiaries. Congress was gravely concerned with "mismanagement of funds" and the "failure to pay employees benefits from accumulated funds." *Dillingham*, 519 U.S. at 326-27 (quoting *Massachusetts v. Morash*, 490 U.S. 107, 115 (1989)). Congress wanted employers to keep their promises to employees and wanted funds to be preserved for their intended uses, not squandered through malfeasance or negligence. *See* 29 U.S.C. § 1001(b) (declaring ERISA's policy to protect plan participants and their beneficiaries). "To that end, [Congress] established extensive reporting, disclosure, and fiduciary duty requirements to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator." *Dillingham*, 519 U.S. at 327 (quoting *Morash*, 490 U.S. at 115).

Second, ERISA provides an "integrated enforcement mechanism" against plan administrators that Congress intended to be "exclusive." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208-09 (2004) (construing 29 U.S.C. § 1132). State laws that "provid[e] alternative enforcement mechanisms" against plan administrators are generally preempted. *Travelers*, 514 U.S. at 658.

Third, Congress sought to establish a "uniform body of *benefits* law" that avoids "conflicting directives" and allows for "nationally uniform administration of

employee benefit plans." *Travelers*, 514 U.S. at 657 (emphasis added, quotations omitted). In this context, "uniform administration" refers to the provision and funding of benefits. States thus may not require "employers to pay employees specific benefits," *id.* (quoting *Shaw*, 463 U.S. at 97); prohibit plans from "requiring reimbursement in the event of recovery from a third party," *id.* (quoting *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990)); prohibit set-offs for worker's compensation benefits, *id.* at 658 (citing *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981)); or change the rules for beneficiary designations, *see Egelhoff v. Egelhoff*, 532 U.S. 141 (2001) (state law preempted because it automatically revoked, upon divorce, designation of a spouse as the beneficiary of a nonprobate asset); *Boggs v. Boggs*, 520 U.S. 833 (1997) (state community property law preempted insofar as it would assign ownership interest in ERISA plan benefits to person other than designated beneficiary).

But ERISA does not preempt every state law that has some effect on an ERISA plan or regulates some aspect of plan activities. There are, as the Court has observed, "myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate." *Travelers*, 514 U.S. at 668. That these state laws impose costs and administrative burdens on a plan is unremarkable—ERISA did not transform plans into islands isolated from all regulation—and not a basis for finding preemption. *See, e.g., De Buono*, 520 U.S. at 815 (upholding state hospital tax that increased cost for plans and "impose[d] some burdens" on plan administration) (quotations omitted); *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 831

(1988) (holding that ERISA did not preempt application of generally applicable state garnishment statute to benefits held by ERISA plan, despite plan's contention that compliance would impose "substantial administrative burdens and costs"); *see also Travelers*, 514 U.S. at 662 (noting that, in *Mackey*, the Court "took no issue with the argument . . . that garnishment would impose administrative costs and burdens upon benefit plans").[15] Although Congress sought to foster uniform benefit plans, its preemption of state laws that "relate to" ERISA plans did not mandate "a degree of preemption that no sensible person could have intended." *See Dillingham*, 519 U.S. at 335-36 (Scalia, J., concurring).

By focusing on Congress's objectives in enacting ERISA, the Court properly limited the reach of the statute's preemption clause. ERISA preempts state laws that direct the amount, type, or nature of benefits paid to beneficiaries; regulate the structure of the plan; or otherwise interfere with the relationship between a plan and its members. *See, e.g., De Buono*, 520 U.S. at 814-15 (distinguishing permissible tax on hospitals from state laws that address "calculating of pension benefits" or require payment of specific benefits); *Travelers*, 514 U.S. at 658 (describing past decisions where "ERISA pre-empted state laws that mandated employee benefit structures or their administration"); *see also Egelhoff*, 532 U.S. at 150 (ERISA

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[15] The Court has left open the possibility that a state law might impose economic burdens "so acute as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers' and such a state law 'might indeed be pre-empted under [29 U.S.C. § 1144].'" *De Buono*, 520 U.S. at 816 n.16 (quoting *Travelers*, 514 U.S. at 668). Neither Liberty Mutual nor the lower court has suggested that Vermont's database requirements even approach this standard. *See* Opp. 19-20 & n.9.

preemption was intended to avoid "different state regulations affecting an ERISA plan's 'system for processing claims and paying benefits.'") (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987)). It does not preempt a law like Vermont's database law, which is utterly indifferent to—and indeed incapable of assessing—whether ERISA plans remain solvent, behave prudently, or keep their insurance promise.

2. Congress also did not intend ERISA to displace ordinary state health care regulations. Under *Travelers* and *De Buono*, those seeking to preempt generally applicable state laws that govern the health care industry from applying to ERISA plans face a "considerable burden." *De Buono*, 520 U.S. at 814. "[N]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. at 661.

Consistent with this understanding of Congress's intent, the Court in *Travelers* upheld a New York regulation of hospital rates that imposed additional costs on commercial health insurers acting as fiduciaries for ERISA plans. The law required hospitals to charge commercial insurers up to 24% more than Medicaid and Blue Cross/Blue Shield plans. *Id.* at 650. The Second Circuit—which held the law preempted—observed that the surcharges were "meant to increase the costs of certain insurance" and "impose[d] a significant economic burden" on the plans. *Id.* at 654. This Court reversed, explaining that a broad range of state health care regulations "affect[] costs and charges" for ERISA plans purchasing health insurance coverage and are not preempted. *Id.* at 661.

The Court reiterated this point in *De Buono*, where the Second Circuit had struck down a state tax on hospital revenues as applied to a hospital operated by an ERISA plan. The lower court had "rested its conclusion in no small part on the fact that" the tax targeted the health care industry. *De Buono*, 520 U.S. at 814 n.10. This Court reversed, noting that, "[r]ather than warranting pre-emption," that point instead called for applying the presumption against preemption. *Id.* "'[M]yriad state laws' of general applicability . . . impose some burdens on the administration of ERISA plans." *Id.* at 815. The tax did not target ERISA plans, because "[m]ost hospitals are not owned or operated by ERISA funds." *Id.* at 816. That the tax "increase[d] the cost of providing benefits to covered employees," and thus had "some effect on the administration of ERISA plans," was not enough to find preemption. *Id.*

ERISA regulates employee benefit plans. It does not regulate health care. Those central teachings, distilled from *Travelers* and later cases, confine ERISA preemption to a reasonable scope and avoid the "unsettling result," *Travelers*, 514 U.S. at 665, of invalidating large swaths of state law regarding matters "where ERISA has nothing to say," *Dillingham*, 519 U.S. at 330.[16]

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[16] Several justices have suggested that ERISA's preemption clause may be better understood as "identify[ing] the field in which ordinary *field pre-emption* applies—namely, the field of laws regulating" employee benefit plans covered by ERISA. *Dillingham*, 519 U.S. at 336 (Scalia, J., concurring, joined by Ginsburg, J.); *see also Egelhoff*, 532 U.S. at 153 (Scalia, J., concurring, joined by Ginsburg, J.) (arguing that "relate to" should be interpreted as "a reference to "ordinary pre-emption jurisprudence"); *id.* at 153 (Breyer, J., dissenting, joined by Stevens, J.) (agreeing with Justice Scalia that Court "should apply normal

B. Vermont's law does not intrude on a core ERISA function and is not the type of law that Congress intended ERISA to preempt.

Applying these settled principles, Vermont's law must be upheld. First, the health care database statute is the type of "general health care regulation" that Congress left undisturbed when it adopted ERISA. Second, the database statute merely requires that third-party administrators provide after-the-fact claims data for self-insured plans in the same way that they provide data for other plans and insureds. Nothing about this requirement intrudes on a core ERISA function or in any way changes the terms of the benefit plan. Third, other federal statutes coupled with consistent federal support for state data-collection programs confirm that Liberty Mutual's assertion of federal preemption has no reasonable basis.

1. Vermont's law is an exercise of traditional and longstanding state authority to regulate health care.

The decision of Vermont and other States to create all-payer claims databases implicates longstanding state oversight of health care. The Second Circuit erroneously concluded that these "health data collection laws" do not fall within the "states' historic police powers." App. 18 n.8. In fact, States need comprehensive, high-quality data to carry out their traditional role of safeguarding public health as the primary regulators of health care providers and the health care market. And although the particular type of data collection at issue in this case is relatively new, States'

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conflict pre-emption and field pre-emption principles"). If viewed through a field preemption lens, the result is the same: *Travelers* and *De Buono* establish that health care regulation is outside of the preempted field governed by ERISA.

interest in collecting health information is not. From controlling contagious diseases over a century ago to federally supported health planning efforts in the 1970s, States routinely have collected health information to protect the public and better manage their health care systems. *See supra* pp. 4-8. This is no different.

The uses of data from VHCURES and other States' databases prove this point. Health care databases serve the States' traditional interests in protecting public health, regulating the health care industry, and developing health care policy. *See supra* pp. 12-16. In concluding otherwise, the Second Circuit drew an artificial distinction between collecting information and regulating the safe provision of health care.

First, health care databases are vital public health programs. States cannot reasonably be expected to oversee health care providers, support disease prevention, and improve the quality of health care without systematically collecting and analyzing health care data. Research conducted across the country confirms this point. Colorado is studying claims data to evaluate post-surgery prescriptions for opioids, in an effort to increase patient safety by reducing unnecessary use of addictive painkillers.[17] The Dartmouth Institute relies on data from three state databases to track children's health care in northern New England. *See supra* p. 14. New Hampshire has looked at problems with local access to medical services, while Utah uses its data to study preventive care. A regional pilot project in New York found a high rate of unnecessary hysterectomies. *See* New York et al. Cert. Amicus. Br.

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[17] *See* APCD Showcase, *Identify Opportunities to Reduce Use of Potentially Harmful Medications During and Post Surgery* (2015), http://www.apcdshowcase.org/case-studies/.

5-6. In Vermont, the health care database supports the Blueprint for Health, the State's federally recognized program aimed at improving the treatment of chronic diseases such as diabetes, asthma, and heart disease. *See supra* pp. 13-14.

Second, Vermont, like other States, needs accurate information about the health care market to carry out traditional state regulatory functions. As in many States, health insurers in Vermont must submit their proposed rates for review and approval. *See* Vt. Stat. Ann. tit. 8, § 4062(a)(1), (3).[18] In reviewing rates, the Green Mountain Care Board relies in part on information about health care spending and utilization drawn from VHCURES. And the Board's review of hospital budgets, a longstanding part of the State's effort to control health care costs, also draws on VHCURES. *See supra* p. 15. Without data from self-insured plans—which pay for health care services for a substantial number of Vermont residents—VHCURES would be far less complete and accurate, and thus materially less useful, for these purposes.

Third, comprehensive all-payer databases are a tool for addressing one of the most serious budget and public policy issues facing States: the ever-increasing cost of health care. The annual growth in health care spending has outstripped inflation for decades.[19]

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[18] The scope of rate review varies by State, but the majority of States have some process for reviewing health insurance rates. *See, e.g.*, Kaiser Family Found., *Rate Review: Spotlight on State Efforts to Make Health Insurance More Affordable* 19-23 (2010), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8122.pdf.

[19] *See, e.g.*, CMS, Historical National Health Expenditure Data, Table 2, https://www.cms.gov/Research-Statistics-Data-

Controlling the rate of growth is crucial to the long-term fiscal outlook for state governments. *See, e.g.*, U.S. Gov't Accountability Office, *State and Local Governments' Fiscal Outlook* 5 (2014 Update) (noting that "growth in health-related costs" is "a primary driver of long term-fiscal challenges for the state and local government sector").[20] Put more simply, the ability of a State to balance its budgets for the next several decades will depend in substantial part on whether all levels of government achieve success in bending that cost curve. *See id.* at 2 (given rising health care costs, state and local governments "need to make substantial policy changes to avoid fiscal imbalances that would likely grow in the future").

Vermont has invested in its all-payer database because it is the most effective means of assembling the comprehensive data the State needs to develop and evaluate policies aimed at controlling health care costs. *See, e.g.*, Vt. Stat. Ann. tit. 18, § 9410(a)(1)(B), (D), (F) (purposes include "informing health care policy," comparing costs, and "improving the quality and affordability" of health care); *see supra* pp. 15-16 & n.13 (noting state reports and studies drawing on VHCURES data). One of the primary statutory directives to the Green Mountain Care Board, which maintains the database, is to "reduc[e] the per capita rate of growth in expenditures" while "maintaining quality of care." Vt. Stat. Ann. tit. 18, § 9372. As just one example of the ways in which it pursues that dual directive, the Board supervises payment-reform pilot projects that move away from paying providers for specific services and, instead, develop payment

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and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html.

[20] *Available at* http://www.gao.gov/assets/670/667623.pdf.

systems that reward better care and better patient outcomes. *See generally id.* § 9377. The goal is to find better ways to pay for health care—not by trying to change the entire system, all at once, but by designing and implementing smaller projects and studying their success. VHCURES, with its statewide data on utilization and spending, is essential to both developing reform proposals and evaluating their successes or failures.

Other States with all-payer claims database statutes agree that these laws "provide the States with data they need to improve the quality of care while controlling costs." New York et al. Cert. Amicus. Br. 4. The States will not all adopt identical policies to meet these challenges. But the widespread commitment of public resources to establish these databases —in States as diverse as Vermont, New York, West Virginia, Utah, and Colorado—represents a common effort to craft policy based on the best information available. No one can fix a system that no one understands.

The Second Circuit's suggestion that these important tools for collecting health care data are somehow outside the States' historic police powers is thus mistaken. The databases that Vermont and other States have created serve broad public health and health policy purposes. This is precisely the kind of "general health care regulation" that "historically has been a matter of local concern" and that Congress did not intend ERISA to override. *Travelers*, 514 U.S. at 661.

2. Vermont's law does not intrude on a core ERISA function and has nothing to do with ERISA's plan reporting requirements.

Although Vermont's law serves critical information-gathering functions, it is limited in scope. The health care database statute does not regulate the terms of an employee benefit plan, interfere with the relationship between a plan and its members, or supervise plan funding or fiduciary obligations. Moreover, the information Vermont seeks would not even be useful for any of those purposes. The State is not asking for any information about the terms of the plan or its funding. App. 118-21. Nor is it asking for information about claims that are denied. App. 121. The names of plan members are encrypted and the use of VHCURES data to evaluate particular employers is prohibited. App. 110, 129, 135. In short, the information Vermont seeks about statewide health care utilization and spending has no connection with those areas that ERISA carves out as matters of federal concern. Given this sharp disconnection between the objectives of ERISA and the purpose and effect of Vermont's database, there is no reasonable basis for holding this state health care regulation preempted.

a. The nature and purpose of ERISA's reporting requirements show that Vermont's law is not preempted. Consistent with the Court's reasoning in *Travelers*, the proper focus is on what Congress intended ERISA to accomplish. *See* 514 U.S. at 656 (looking to "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive"). And what animated ERISA's reporting and disclosure requirements was the need to protect plan beneficiaries. ERISA's policy

statement declares that, "owing *to the lack of employee information* and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries . . . *that disclosure be made* and safeguards be provided with respect to the establishment, operation, and administration of such plans." 29 U.S.C. § 1001(a) (emphases added). Congress expressly tied the disclosure and reporting standards to the federal interest in protecting plan participants:

> It is . . . the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

Id. § 1001(b).

This Court's precedents acknowledge the same point. "The principal object of [ERISA] is to protect plan participants and beneficiaries." *Boggs*, 520 U.S. at 845. As the Court explained in *Massachusetts v. Morash*, "Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds." 490 U.S. at 115. It was, the Court has repeatedly noted, "*to that end*" that Congress "established extensive reporting, disclosure, and fiduciary duty requirements." *Id.* (emphasis added); *see also Dillingham*, 519 U.S. at 326-27 (same). The federal government, which enforces the reporting and disclosure requirements, agrees that ERISA plan

reporting requirements "serve the basic purposes of ERISA," namely, preventing mismanagement of funds and failure to pay benefits. U.S. CVSG Br. 13; *see id.* at 2-3 (describing ERISA's reporting requirements).

Vermont's collection of after-the-fact health care claims information from all payers, including third-party administrators of self-insured ERISA plans, in no way intrudes on these areas of federal concern and regulation. The program is not directed at ERISA plans as *plans*. VHCURES has "an entirely different focus," *id.* at 13: collecting statewide paid claims data as a tool for improving public health and guiding health care policy. The database requirements apply across-the-board to public and private health care payers. Indeed, Liberty Mutual's third-party administrator, a major health insurer, provides the same claims data to the database whether the person receiving benefits is part of an ERISA plan or not.[21]

The information provided to VHCURES contributes to a comprehensive picture of health care spending and utilization. But it does not provide any path to assess the administration or audit the financing of an employee benefit plan. Vermont could not evaluate whether a plan has provided the benefits promised to employees, because it does not collect information about the plan terms and does not ask for information about claims denied by the plan.[22] Likewise, Vermont

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[21] In 2010, the year before this suit was filed, Blue Cross Blue Shield of Massachusetts supplied claims data to VHCURES for more than 7,000 covered individuals, about half of whom were covered by self-insured plans for which Blue Cross served as third-party administrator. JA205.

[22] Review of the "claims procedure" set forth in plan documents further illustrates that the database statute has no relationship to the plan's administration of claims. The plan directs how a

could not evaluate whether a plan is adequately financed, because it does not collect information about finances. When data are used for research purposes, employer and purchaser groups may not even be disclosed. App. 135. The database statute serves broad public policy goals. It does not protect beneficiaries or supervise the relationship between the plan and its members.

In holding Vermont's law preempted, the Second Circuit failed to consider the nature and purpose of ERISA's reporting requirements—indeed, the court criticized the dissent for engaging in that analysis and ignored the federal government's arguments on this point. *See* App. 24 n.11, 29 n.13; U.S. C.A. Br. 12-13 (explaining that Vermont's law does not affect the relationship between the plan and its members and does not serve the same purpose as ERISA's reporting requirements). But that is precisely the inquiry called for by this Court's precedents. *See Travelers*, 514 U.S. at 656; *Dillingham*, 519 U.S. at 325; *De Buono*, 520 U.S. at 813-14. Vermont's health care database does not affect employee benefit plans in any way that undermines the objectives of ERISA.

b. Moreover, the Second Circuit's contrary conclusion is based on a mistaken premise: that, because ERISA requires certain plan reporting and disclosures, reporting information of any kind must be deemed a "core ERISA function." App. 23-24. ERISA's reporting and disclosure requirements, however, are designed to help achieve the statute's key objectives:

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claim must be filed, the time for decision, and the appeal process for denied claims. JA44-46. The claims data submitted to VHCURES would not even reveal that process, much less affect it. The paid claims data disclose the final amount paid to providers and the services for which payment is made.

protecting beneficiaries, ensuring financial solvency, and facilitating uniform plan administration. ERISA plans provide an annual report to the Secretary of Labor, *see* 29 U.S.C. § 1023, which is "principally concerned with the financial soundness of the plan." U.S. C.A. Br. 12.[23] The plan's disclosure to plan participants, *see* 29 U.S.C. §§ 1021-1022, "is essentially a plain-English summary of key plan terms." U.S. C.A. Br. 12. By setting a federal standard for these disclosures, ERISA allows plans to send the same notices to all participants, wherever they live, and ensures that members receive a consistent, fair explanation of the plan. ERISA sets those requirements, and States cannot alter or duplicate them. *See* U.S. CVSG Br. 13 ("Any state-law reporting requirements serving the same functions would raise a substantial preemption question.").

But the fact that Congress adopted plan reporting requirements for the purpose of protecting beneficiaries, *see Dillingham*, 519 U.S. at 326-27, does not mean —as the Second Circuit incorrectly concluded—that requiring a plan to provide information for any purpose, in any context, intrudes on a core ERISA function. *See* App. 24. Plans necessarily engage in a wide range of activities that might trigger state-law requirements to keep records or provide information to a state or local government. Plans may purchase real estate, and need to comply with recording, reporting, and property tax requirements.[24] State tax laws

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[23] As a general matter, welfare plans are exempt from most reporting requirements. *See* U.S. CVSG Br. 2; 29 C.F.R. §§ 2520.103-1, 2520.104-20, 2520.104-44.

[24] *See, e.g.*, Vt. Stat. Ann. tit. 32, § 4004 (requiring every "taxable person" to prepare and return inventory forms for property tax purposes); *id.* §§ 9602, 9606 (imposing tax on transfer of title

or prevailing wage laws may require information from plans. *Cf. De Buono*, 520 U.S. at 809-10, 815-16; *Dillingham*, 519 U.S. at 330, 334. ERISA contemplates that plans may offer not just health benefits, but day care centers, training programs, and legal services. 29 U.S.C. § 1002(1). ERISA health plans may run hospitals or medical centers. *See De Buono*, 520 U.S. at 810 (noting that ERISA plan "owns and operates three medical centers"). Given the breadth of possible investing activities for pension plans and the range of services that a welfare plan might provide, Congress could not have contemplated that plans would be essentially exempt from generally applicable state regulations in these fields.

In concluding otherwise, the Second Circuit relied on a "literal approach to preemption" that both the Sixth Circuit and the dissent rightly criticized. *Self-Ins. Inst. of Am., Inc. v. Snyder*, 761 F.3d 631, 639 (6th Cir. 2014) (*SIIA*), *petition for cert. pending*, No. 14-741 (filed Dec. 18, 2014); App. 32 (Straub, J., dissenting) (noting that "majority's argument misses the nuance of what 'reporting' means in the context of ERISA"). The Second Circuit reasoned that reporting means "record-keeping and filing with a third party," App. 24, and Vermont's statute is titled a "'Healthcare Claims Uniform *Reporting* and Evaluation System,'" *id.* In so doing, the court committed an error similar to the one identified in *De Buono*, where this Court noted that the court of appeals "fail[ed] to give proper weight to *Travelers*' rejection of a strictly literal

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and requiring a "property transfer return" to "be delivered to a town clerk at the time a deed evidencing a transfer of title to property is delivered to the clerk for recording"); *id.* tit. 27, § 342 (recording of deeds).

reading" of ERISA's preemption clause. 520 U.S. at 812-13.

This Court has never held that all state laws that require plans to provide information intrude on a core ERISA function. *Fort Halifax*, upon which the court below relied (App. 16-17), certainly does not go so far. In that case, the Court upheld a Maine statute that required one-time severance payments to certain employees. The Court held that the law neither required employers to establish plans nor "create[d] the potential for the type of conflicting regulation of benefit plans that ERISA was intended to prevent." 482 U.S. at 14.

The Second Circuit placed great weight on the Court's observation, in finding Maine's statute not preempted, that ERISA preemption is intended to allow for a "uniform administrative scheme" and to avoid "differing regulatory requirements in different States." App. 16-17 (quoting *Fort Halifax*, 482 U.S. at 9). Read in context, however, *Fort Halifax* highlighted Congress's concern with "conflicting or inconsistent" state laws requiring certain kinds of benefits, claims processing, or fiduciary standards. 482 U.S. at 9 (quotations omitted). The Court noted that ERISA prevents conflicting state laws that would require a plan "to make certain benefits available," "to process claims in a certain way," or "to comply with certain fiduciary standards in some states but not in others." *Id.* The Court's reference to state laws that would require a plan "to keep certain records in some states but not in others" must be read in the same context—as related to state regulations that interfere with the plan's uniform administration of benefits. *Id.* at 9-11 (citing *Shaw* and noting concern that States would mandate different types of benefits); *see also Egelhoff*,

532 U.S. at 150 (noting that ERISA preemption avoids "differing state regulations affecting an ERISA plan's 'system for processing claims and paying benefits'") (quoting *Fort Halifax*, 482 U.S. at 10).

In any event, the lower court's broad reading of *Fort Halifax* cannot be reconciled with this Court's later decisions, which upheld generally applicable state statutes that imposed administrative burdens—including informational and recordkeeping requirements—on plans. The garnishment statute upheld in *Mackey* required plans to become parties to litigation, respond to a summons, and deposit funds (moneys otherwise due beneficiaries) into court. *See* 486 U.S. at 831. Despite these burdens, the court held that "Congress did not intend to forbid the use of state-law mechanisms of executing judgments against ERISA welfare benefit plans." *Id.* at 831-32; *see also Travelers*, 514 U.S. at 662 (re-affirming *Mackey*). *Dillingham* upheld California's prevailing wage laws and apprenticeship standards, 519 U.S. at 330, 334—laws that necessarily required ERISA plans to maintain records. *See id.* at 332-34 (noting plans faced choice of complying with standards or paying apprentices higher wages as required by prevailing wage statute).[25] *De Buono* upheld, as applied to plan-run facilities, a tax on the gross receipts of hospitals and other medical centers. *See* 520 U.S. at 809-10, 815-16. And state tax laws, without doubt, require taxpayers to keep records and provide information to the government. *See SIIA*, 761

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[25] *See also New Jersey Carpenters & Trustees v. Tishman Constr. Corp.*, 760 F.3d 297, 300 (3d Cir. 2014) (observing that state prevailing wage statute "requires that every contractor and subcontractor keep a record detailing the worker's name, his or her craft or trade, and actual hourly rate of wages paid to each worker" and preserve records for two years).

F.3d at 638 (noting that "neither *Travelers* nor *De Buono* explicitly concerned reporting requirements regarding the taxes, but those requirements were essential parts of the tax schemes and drew no comment").[26]

c. Liberty Mutual mistakenly insists that the health care database statute must be preempted because it requires "reporting of information 'about the essential functioning of employee health plans.'" Opp. 17 (quoting App. 29 n.13). Again, the data supplied to VHCURES do not identify plan participants, exclude denied claims, and say nothing about the terms of a plan or its funding. That is hardly a detailed report on the administration of an employee benefit plan. *See* App. 38 (Straub, J., dissenting) (noting that "Vermont does not seek information on plan assets, and does not review the allocation or denial of benefits"). If Liberty Mutual's suggested standard—that States cannot seek information related to "essential functions"—is broad enough to include Vermont's data collection, it would also cast doubt on common state laws that protect public health and safety. Plan-run hospitals would not have to report infections, mortality, or other public health data. Day care centers run by ERISA plans could not be required to report on attendance, safety measures, or teacher qualifications. States could impose taxes and prevailing wage standards, but not collect the information needed to enforce those laws from ERISA plans. *Travelers* and *De Buono* rejected such an expansive application of ERISA preemption.

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[26] As the Sixth Circuit noted, the tax upheld in *De Buono* "required '[e]very hospital [to] submit reports on a cash basis of actual gross receipts received from all patient care services.'" *SIIA*, 761 F.3d at 638 (quoting N.Y. Pub. Health Law § 2807-d(7)(a) (McKinney 1993)).

d. Because Vermont's law does not intrude on any core ERISA function, the Second Circuit's extended discussion of the supposed burdens of providing claims data was irrelevant. (It was also unsupported and factually incorrect, as discussed below. *See infra* pp. 52-56.) The court's holding that ERISA permits only a "slight" burden on plans, App. 24, is unsupported by precedent. ERISA does not preempt generally applicable laws merely because they place some financial or other burdens on ERISA plans. Indeed, that is precisely the proposition that *Travelers* —followed by *De Buono* and *Dillingham*—rejected. As the dissenting judge below recognized, "[m]any state laws may have an impact on the administration of an ERISA plan" and "impose additional costs" or "require additional administrative resources." App. 42 (Straub, J., dissenting). Providing claims data to state databases may impose some costs on third-party administrators for plans, just as the garnishment proceedings, rate surcharges, and taxes in *Mackey*, *Travelers*, and *De Buono* imposed costs. Liberty Mutual did not prove that fact, *see infra* p. 54, but, even if it is true, database laws nonetheless have no significant connection with ERISA plans and are not preempted.

3. Other federal enactments and federal support for state data-collection programs provide further evidence that Vermont's health care database statute is not preempted.

Not only do the purposes of ERISA weigh decisively against preemption, so too do other federal statutes and programs that encourage, support, and rely on state data-collection programs. Here, as in *Travelers*, other statutes passed contemporaneously with ERISA both are relevant and confirm that Congress did not

intend to preempt state efforts to collect and analyze health care information. *See Travelers*, 514 U.S. at 664-67 & n.6. Later federal statutes and programs only strengthen the case against preemption. The federal government has consistently supported both state data-collection programs and health care policies that depend on those data.

a. This Court's ruling in *Travelers* was informed in part by a statute adopted within a few months of ERISA, the National Health Planning and Resources Development Act of 1974 (NHPRDA), which encouraged States to regulate health care rates. *See* 514 U.S. at 665-66. Interpreting ERISA to preempt rate regulation, the Court noted, "would have left States without the authority to do just what Congress was expressly trying to induce them to do." *Id.* at 667. Both that reasoning and NHPRDA itself are relevant here and show that Congress likewise could not have intended ERISA to preempt state data-collection efforts.

NHPRDA, as the Court recognized in *Travelers*, promoted and funded "regional 'health systems agencies' *responsible for gathering data* as well as for planning and developing health resources." 514 U.S. at 665 (citing § 3, 88 Stat. 2229-2242) (emphasis added). Part of Congress's charge to those agencies was to "assemble and analyze data concerning," among other things, the health care delivery system and its use, "the number, type, and location of the area's health resources, including health services, manpower, and facilities," and "patterns of utilization." NHPRDA § 3, 88 Stat. 2236 (adding § 1513(b) to the Public Health Service Act (PHSA), codified at 42 U.S.C. § 300*l*-2(b) (1976) (repealed 1986)). NHPRDA, in turn, cross-referenced, *see id.*, another federal statute passed earlier that

year, the Health Services Research, Health Statistics, and Medical Libraries Act of 1974. That statute created the National Center for Health Statistics and directed the Center to, among other things, assist "in the design and implementation of a cooperative system for producing comparable and uniform health information and statistics at the Federal, State, and local levels." § 105, 88 Stat. 365-66 (adding § 306(e) to the PHSA, codified at 42 U.S.C. § 242k(e) (1976)). *See supra* pp. 6-7.

These federal programs, contemporaneous with the adoption of ERISA, provide necessary context for evaluating the scope of Congress's intent in ERISA to preempt state laws. The same Congress that passed ERISA was also deeply concerned with health care reform, and it contemplated both a substantial state role in developing health care policy and reliance on comprehensive data about state health care systems. *See Travelers*, 514 U.S. at 665-67. Here, as in *Travelers*, it "just makes good sense" to reject a broad interpretation of ERISA preemption that would leave "States without the authority to do" the work that other federal statutes promoted and supported. *Id.* at 667.

b. Moreover, although this part of NHPRDA was repealed in 1986, federal laws and policies continue to "encourage and rely on state experimentation." *Travelers*, 514 U.S. at 667 n.6. *Travelers* noted that the "history of Medicare regulation," including waivers and implementing programs that post-date ERISA, "confirm[] that Congress never envisioned ERISA pre-emption as blocking state health care cost control." *Id.* Medicare and Medicaid waiver programs still exist. Among other things, the federal government supports state "all-payer" models for health care

payment and delivery. *See* U.S. CVSG Br. 21; 42 U.S.C. § 1315a(b)(2)(B)(xi) (contemplating "[a]llowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State"). Evaluating those models depends upon state claims databases. *See* U.S. CVSG Br. 21-22; 42 U.S.C. § 1315a(b)(4) (requiring evaluation of models, including review of quality of care and changes in spending). Indeed, the federal government has provided grants to fund database development, as States "test and evaluate" innovative health care delivery models.[27]

Vermont's Global Commitment waiver for Medicaid allows the State to use federal funds for certain public health initiatives and infrastructure. Some of those funds are used to support VHCURES. VHCURES also collects and processes Medicaid claims data.[28]

c. The fact that Congress has specifically authorized providing Medicare claims data to States seriously weakens any argument for federal preemption. The Secretary of Health and Human Services may

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[27] *See, e.g.*, CMS, State Innovation Models Initiative: Model Test Awards Round Two, http://innovation.cms.gov/initiatives/state-innovations-model-testing-round-two/; *see also* New York et al. Cert. Amicus Br. 3 (describing $6.5 million federal grant for Connecticut's database).

[28] *See* CMS, Expenditure Authority, Global Commitment to Health Section 1115 Demonstration, at 3 (authorizing expenditures for certain "public health initiatives" and "infrastructure"), http://dvha.vermont.gov/administration/2vt-global-commitment-expenditure-authority-cms-approved-10-2-13.pdf; 2015 Vt. Acts & Resolves No. 58, § E.345; Dep't of Vt. Health Access & Green Mountain Care Bd., Memorandum of Understanding, *available at* http://dvha.vermont.gov/administration/sfy15-gmcb-mou-signed.pdf; Dep't of Vt. Health Access & Green Mountain Care Bd., Memorandum of Understanding, *available at* http://dvha.vermont.gov/administration/gmcb-dvha-mou-signed.pdf.

provide the claims data to "qualified entities," including States, that "use claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use." 42 U.S.C. § 1395kk. As the United States has explained, this provision shows that Congress "recogniz[es] the importance of access to comprehensive claims data for healthcare evaluation purposes." U.S. CVSG Br. 22. It would hardly make sense for Congress to take steps to provide access to Medicare claims data to States, if ERISA stood as a roadblock to building comprehensive all-payer databases.

d. Finally, the Patient Protection and Affordable Care Act (ACA), too, acknowledges and preserves the States' primary role in regulating health care. Even with this substantial investment of federal resources in expanding health care coverage, Congress adhered to a federalist structure. *See, e.g.*, 42 U.S.C. § 18041 (state flexibility in establishing and operating exchanges); *id.* § 18052 (waivers for state innovation); *id.* § 18041(d) ("[n]othing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title").

Not only do States continue to regulate health insurers, but also the federal government has expressly supported and helped fund the use of all-payer databases for this purpose. The ACA, which mandates certain rate reviews, preserves the States' regulatory role so long as States are able to conduct those reviews effectively. *See, e.g.*, 45 C.F.R. § 154.210. Just last year, the federal government awarded the Green Mountain Care Board a million-dollar-plus grant, in part to "expand its use of its All-Payer Claims Database (VHCURES) to support its efforts to integrate rate review into the larger landscape of health care

reform activities and increase medical pricing transparency."[29] Grants to other States also support use of APCDs to improve the rate review process.[30]

The federal government's consistent respect for the States' traditional role in regulating health care and its partnering with States to develop and review innovative programs make the case for finding Vermont's database law preempted especially weak. There is no reason to think that Congress intended ERISA to block States' access to critical information about their health care markets while at the same time expecting States to administer complex health care systems, regulate health insurers, and experiment with payment reform and other innovative policies.

C. Because the Court presumes that Congress did not intend to preempt state law, any question regarding the scope of preemption must be resolved in Vermont's favor.

Given the "purpose and the effects" of Vermont's law, *Travelers*, 514 U.S. at 658, its minimal effect on ERISA plans, and consistent federal support for state collection of health care data, there is no question that this is the type of state law that "Congress understood would survive." *Id.* at 656. Were there any doubt, however, it would be erased by Liberty Mutual's failure to meet its "considerable burden of overcoming" the presumption against preemption. *De Buono*, 520 U.S. at 814. This Court has "unequivocally concluded" that ERISA's preemption language does not "modify

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[29] CMS, Vermont Rate Review Grants Award List, https://www.cms.gov/cciio/Resources/Rate-Review-Grants/vt.html.

[30] *See* CMS, Rate Review Grants, https://www.cms.gov/cciio/Resources/Rate-Review-Grants/ (describing grants involving APCDs made to, among others, California, Colorado, New Hampshire, New York, Rhode Island, and Utah).

'the starting presumption that Congress does not intend to supplant state law.'" *Id.* at 813 (quoting *Travelers*, 514 U.S. at 654). "[W]here federal law is said to bar state action in fields of traditional state regulation, [the Court has] worked on the assumption that the historic police powers of the States were not to be superseded . . . unless that was the clear and manifest purpose of Congress." *Travelers*, 514 U.S. at 655 (citation and quotations omitted).

Although the Second Circuit resisted the presumption against preemption on the ground that Vermont's database program does not regulate health care directly, App. 18-19 n.8, this Court's precedents teach otherwise.[31] Both *Travelers* and *De Buono* illustrate that the State's police powers extend more broadly than regulating "the safe and effective provision of health care services." *Id.* In *Travelers*, the Court applied the presumption to state-mandated hospital surcharges that gave preferential treatment to certain insurers and payers. 514 U.S. at 649-50, 655, 658. And, in *De Buono*, the Court criticized the Second Circuit for failing to apply the presumption to a state tax on hospital revenues. 520 U.S. at 814 & n.10. Though the tax was a "revenue raising measure, rather than a regulation of hospitals, it clearly operate[d] in a field that has been traditionally occupied by the States." *Id.* at 814 (quotations omitted). That the tax targeted the health care industry "support[ed] the application

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[31] The Second Circuit also declined to apply the presumption against preemption because "collecting data can hardly be deemed 'historic'—most such laws were enacted only within the last ten years." App. 18 n.8. The court was wrong about the history of health data collection, *see supra* pp. 4-8, but, regardless, the Court has not held that new forms of public health regulation fall outside the States' historic police powers.

of the 'starting presumption' against pre-emption." *Id.* at 814 n.10.

Liberty Mutual has offered no evidence or argument sufficient to overcome the presumption. Liberty Mutual's consistent refrain has been merely that ERISA preempts any requirement that its third-party administrator "report" on its plan's activities. *See, e.g.*, Opp. 20. At most, Liberty Mutual has contended (though not proven) that complying with the law or other similar laws imposes administrative burdens for its third-party administrator. *See* Opp. 20-21.[32] It has not suggested, nor could it, any cognizable impact on the plan's "system for processing claims and paying benefits." *Egelhoff*, 532 U.S. at 150; *see* App. 44 (Straub, J., dissenting) (noting that no "evidence of a burden on the system for processing claims" was provided, and "the majority points to none"). Liberty Mutual's conclusory arguments do not approach the showing necessary to overcome the presumption against preemption.

II. The Second Circuit's conclusion that Vermont's database law places improper burdens or risk on Liberty Mutual lacks merit and finds no support in the record.

In holding Vermont's law preempted, the Second Circuit assumed that providing information for Vermont's database "is burdensome, time-consuming, and risky." App. 25. But, as the dissenting judge below recognized, "[t]here is no evidence to support

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[32] The Second Circuit noted a potential "risk of fines." App. 29. But Liberty Mutual's third-party administrator risks a fine only for *not* complying with the statute. The same would likely be true if a plan failed to pay a state tax or comply with a prevailing wage law. The fact that a state law has some provision for enforcement does not mean it is preempted.

such a finding." App. 46 (Straub, J., dissenting). The court's analysis of the supposed burdens of complying with Vermont's database statute is deeply flawed.

First, Liberty Mutual itself is not required to report anything to VHCURES. The only reporting obligation relevant here—and the only issue before the Court—is the obligation of Blue Cross to provide its Vermont claims data to VHCURES.[33] In evaluating potential burdens, this fact matters. Blue Cross is a major health insurer that generates claims data as part of its regular business as an insurer and plan administrator. Liberty Mutual admits that Blue Cross has the data. *See* App. 39 (Straub, J., dissenting) ("The Vermont statute asks for after-the-fact information which plan administrators, such as [Blue Cross], already have in their possession.") (citing Oral Arg. Tr. 7-8). And the record shows that Blue Cross provided claims data to VHCURES for thousands of individuals covered by its own plans and other self-insured ERISA plans. JA205. Liberty Mutual's Vermont resident plan members represent only a tiny fraction of that number. There is no evidence or even reason to assume that Blue Cross would incur any significant cost by including the claims data for Liberty Mutual's 137 Vermont beneficiaries in its VHCURES submissions.

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[33] The regulation expressly defines "health insurer" to include third-party administrators. App. 112. With respect to self-insured plans, however, the regulations provide only that the term "may also include, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan." App. 113. Vermont has had no occasion to interpret this latter provision of the regulation and is not aware of any self-insured health plans operating in Vermont without a third-party administrator. The only question in this case is whether VHCURES is preempted as applied to the third-party administrator for a self-insured plan.

In fact, one might reasonably assume the opposite: that the third-party administrator incurred some cost to ensure that the data were excluded.

Second, the court below deemed the reporting requirements "time-consuming" and "burdensome," App. 25, without citing any evidence. Liberty Mutual, which moved for summary judgment in the district court, "failed to provide any details or showing of the alleged burden." App. 39 (Straub, J., dissenting); *see* App. 72-73 n.5 (district court noting that Liberty Mutual "has not submitted any information about any actual burden suffered by itself or [Blue Cross] in producing this information"). Liberty Mutual told the district court that the extent of any burden, whether "heavy" or "relatively light," was irrelevant. C.A. JA356-57 (district court hearing transcript). It suggested to the Second Circuit that providing information is "*per se* burdensome" because "all regulations have their costs." Liberty Mutual C.A. Br. 27-28 (quotations omitted). Here, Liberty Mutual deems the supposed burdens "obvious." Opp. 21. But the absence of a single affidavit attesting to the cost or time required to provide claims data to VHCURES is both revealing and dispositive. The burden here was Liberty Mutual's, both to prove its case and to overcome the presumption against preemption. Certainly the fact that Blue Cross provides *the same information to Vermont* for itself and other plans that it administers conclusively rebuts any assertion of burden. *See* App. 39 (Straub, J., dissenting) ("by all accounts [Blue Cross] is happy to provide the data Vermont has asked for, and it does so for other clients"); App. 72-73 n.5 (Blue Cross "apparently provides the data without protest on behalf of other self-funded plans"); JA205

(in 2010, Blue Cross provided claims data for more than 7,000 individuals).

Third, setting aside the lack of evidence, the court erred in thinking it was "obvious[]" (App. 25) that requiring health care insurers and third-party administrators to submit claims data is particularly costly or burdensome. Insurers generate claims data as part of their everyday business. *See* App. 51 (noting that Blue Cross "generates claims data"). That is how doctors and hospitals get paid. Again, Blue Cross has the information that VHCURES seeks. *See* App. 39 (Straub, J., dissenting) (noting this is "after-the-fact information" that Blue Cross has "in their possession"). Liberty Mutual objects to certain formatting requirements that Blue Cross must satisfy—but just as forms used to be printed in blue or black ink, forms today have certain electronic formatting requirements. That is nothing unusual, particularly for billion-dollar businesses that routinely collect and transmit data. The Second Circuit implied that the amount of information sought necessarily made compliance burdensome. App. 25-27. Here again, the court's assumptions are disconnected from current technology and business practices. Reams of information may be transmitted with a few key strokes.

Fourth, the lower court's suggestion that the VHCURES program jeopardizes patient confidentiality was equally unsupported and incorrect. By rule, personal identifying information is encrypted in a manner that does not allow the underlying data to be recovered. App. 110. The statute unambiguously requires compliance with HIPAA. App. 96. The federal government voluntarily supplies Medicare claims data to VHCURES, on the condition that Vermont protect patient confidentiality. *See* U.S. CVSG

Br. 17-18 n.7. Liberty Mutual supplied no evidence suggesting any breaches of patient privacy by VHCURES. As the dissenting judge below concluded, the court's assertion that providing claims data to VHCURES was "risky" was "nothing more than pure speculation." App. 46 (Straub, J., dissenting).

CONCLUSION

The decision below should be reversed.

Respectfully submitted,

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ALFRED GOBEILLE, in his official capacity as chair of the Vermont Green Mountain Care Board,
Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR RESPONDENT

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QUESTION PRESENTED

Vermont has enacted legislation and issued regulations that require "health insurers" to regularly submit to the State "medical claims data, pharmacy claims data, member eligibility data, provider data, and other information relating to health care" for use in Vermont's unified health care database. Health insurers—which Vermont defines as including, "to the extent permitted under federal law," the administrators of self-insured health care benefit plans—must submit annual registration forms and report claims data at specified intervals (monthly for some insurers) in a format prescribed by the State.

The question presented is:

Whether the Employee Retirement Income Security Act of 1974 preempts Vermont's reporting mandates insofar as they require the submission of data about claims paid under the terms of self-insured plans governed by ERISA.

PARTIES TO THE PROCEEDING

The defendant in the district court and the original appellee was Commissioner Stephen W. Kimbell, in his official capacity as the Vermont Commissioner of Banking, Insurance, Securities, and Health Care Administration. Commissioner Susan L. Donegan was substituted for Commissioner Kimbell when she replaced him in office. The petition in this matter was filed by Alfred J. Gobeille, in his official capacity as Chair of the Green Mountain Care Board. Chair Gobeille was not a party to the proceedings below, and as explained in the brief in opposition (at 10-13), he is not a party to this action entitled to petition for certiorari under 28 U.S.C. §1254(1).

Respondent Liberty Mutual Insurance Company was the plaintiff in the district court and the appellant in the court of appeals.

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IN THE

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR RESPONDENT

JURISDICTION

Petitioner invokes this Court's jurisdiction under 28 U.S.C. §1254(1), but as previously explained (Br. in Opp. 10-13), this Court lacks jurisdiction over the petition because the Chair of the Green Mountain Care Board is not a proper party to seek review of the court of appeals' decision.

CONSTITUTIONAL, STATUTORY, AND REGULATORY PROVISIONS INVOLVED

The appendix to this brief reproduces the pertinent provisions of the Supremacy Clause, U.S. Const. art. VI, cl. 6; the Employee Retirement Income Security

Act of 1974 (ERISA), 29 U.S.C. §§1001 *et seq.*; Vermont's Database Statute, 18 V.S.A. §9410; and Vermont's Regulation H-2008-01.

STATEMENT

A. ERISA And The Exclusively National Regulation Of Benefit Plans

A central objective of the Employee Retirement Income Security Act of 1974 (ERISA) was to establish a uniform, national regime governing employee benefit plans. ERISA allows employers to maintain self-funded health benefit plans on a national basis free from state regulation. Traditionally, private health insurance cannot be purchased from companies located outside the insured's home state. Congress recognized, however, that employers increasingly operate nationwide and that a localized approach to benefit plans would be inefficient and detrimental to employees and beneficiaries. To ensure that employee benefit plans can dedicate resources to providing benefits rather than meeting unnecessary administrative costs, Congress made those plans subject to exclusively federal regulation.

ERISA imposes detailed and comprehensive federal requirements on employee benefit plans.[1] Among other things, under ERISA, "[a]ll employee benefit plans must conform to various reporting, disclosure,

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[1] ERISA regulates two kinds of employee benefit plans: welfare benefit plans and pension benefit plans. 29 U.S.C. §1002(3). This case concerns a welfare benefit plan, which is established to provide health care benefits to employees and beneficiaries, *id.* §1002(1)(A). Although some aspects of the federal regulation of welfare plans and pension plans are distinct, as discussed below, *see infra* pp. 29-30, the preemption principles for the two kinds of plans are identical.

and fiduciary requirements." *Boggs* v. *Boggs*, 520 U.S. 833, 841 (1997). The statute's reporting and disclosure requirements, codified at 29 U.S.C. §§1021-1031, mandate that employee benefit plans file with the Secretary of Labor annual reports containing specified information. *Id.* §§1021-1024. Plans must also maintain books and records concerning the information disclosed in the various reports they file. *Id.* §1027. In addition, ERISA recognizes the Secretary's broad authority to impose reporting requirements on plans to carry out the purposes of ERISA, *id.* §1024(a)(2)(B), and authorizes the Secretary "to undertake research and surveys and in connection therewith to collect, compile, analyze and publish data, information, and statistics relating to employee benefit plans," *id.* §1143(a)(1).

In enacting ERISA, Congress recognized that "employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities" and that "[a] patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation." *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 11 (1987). Congress thus provided in ERISA's preemption provision, 29 U.S.C. §1144(a), that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by the federal law. This Court has "observed repeatedly that this broadly worded provision is 'clearly expansive.'" *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 146 (2001). It ensures that plans are not subject to potentially conflicting regulations in 50 States (in addition to federal ERISA regulations) and that plan resources are, to the extent possible, devoted to the provision of benefits rather than administrative costs.

ERISA also exempts limited kinds of state laws from preemption. ERISA's savings clause, 29 U.S.C. §1144(b)(2)(A), generally exempts from preemption "any law of any State which regulates insurance, banking, or securities." ERISA's "deemer" clause, *id.* §1144(b)(2)(B), limits that exemption, however, by providing that "an employee benefit plan governed by ERISA shall not be 'deemed' an insurance company, an insurer, or engaged in the business of insurance for purposes of state laws 'purporting to regulate' insurance companies or insurance contracts." *FMC Corp.* v. *Holliday*, 498 U.S. 52, 58 (1990). The deemer clause reinforces the preemption provision and ensures that States may not assert authority over self-insured ERISA plans under the guise of their traditional regulation of health insurance. *See id.* at 61.[2]

B. Vermont's Reporting Requirements

1. The Database Statute

This case involves steps that Vermont has taken to bring self-insured ERISA medical plans within the State's regulatory ambit, notwithstanding Congress's express provision that such plans should be subject only to uniform federal regulations. Vermont enacted 18 V.S.A. §9410 (the Database Statute), which requires the creation of a "unified health care database." *Id.*

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[2] Self-insured (or self-funded) plans pay benefits directly out of plan resources, rather than purchasing insurance. The Court has recognized the important distinction between the two kinds of plans and has stressed that self-insured plans are largely immune from state regulation. *See FMC*, 498 U.S. at 61-63. ERISA plans that purchase insurance from an insurance company (fully insured plans) remain indirectly subject to state insurance regulation, insofar as the state insurance regulations apply to the plan's insurer. *Id.* at 61.

§9410(a)(1). The Database Statute requires "[h]ealth insurers, health care providers, health care facilities, and governmental agencies" to file those "reports, data, schedules, statistics, or other information determined ... to be necessary to carry out the purposes" of the statute. *Id.* §9410(c). Although the Database Statute uses the term "health insurers" to define its scope, it is not limited to traditional health insurance companies. "Health insurer" is defined to include

> any third party administrator, any pharmacy benefit manager, any entity conducting administrative services for business, and *any other similar entity with claims data*, eligibility data, provider files, and other information relating to health care provided to a Vermont resident, and health care provided by Vermont health care providers and facilities required to be filed by a health insurer under this section.

Id. §9410(j)(1)(B) (emphasis added). The administrator of a self-insured plan, as well as any third-party administrator with which the administrator contracts, falls within that definition.

Under the Database Statute, information that must be reported "may include: (1) health insurance claims and enrollment information used by health insurers." 18 V.S.A. §9410(c)(1). "Health insurers" must report

> (A) their health insurance claims data, provided that the [Green Mountain Care] Board may exempt from all or a portion of the filing requirements of this subsection data reflecting utilization and costs for services provided in this State to residents of other states;

(B) cross-matched claims data on requested members, subscribers, or policyholders; and

(C) member, subscriber, or policyholder information necessary to determine third party liability for benefits provided.

Id. §9410(h)(1). Although, as discussed below, the regulation that implements the Database Statute does not require collection of data on *denied* claims, the Database Statute does not contain any such limitation and apparently authorizes the implementing agency to seek information about denied claims, and much other information besides.

Information collected under the Database Statute is to be broadly disseminated. "To the extent allowed by [the federal Health Insurance Portability and Accountability Act (HIPAA)]," data collected shall be available to third parties: "[T]he data shall be available as a resource for insurers, employers, providers, purchasers of health care, and State agencies." 18 V.S.A. §9410(h)(3)(B). That data is supposed to be anonymized, however. *See id.* §9410(h)(3)(D).

2. The implementing regulation

Regulation-H-2008-01 implements the Database Statute and creates the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES). The Regulation imposes specific reporting requirements on entities covered by the Database Statute. Under the Regulation, "health insurers" are subject to annual registration requirements and must "identify whether health care claims are being paid for members who are Vermont residents and whether health care claims are being paid for non-residents receiving covered services from Vermont health care

providers." *Id.* §4(A). Section 3(X) defines "health insurer" to include "any health insurance company, nonprofit hospital and medical service corporation, managed care organization, third party administrator, pharmacy benefit manager, and any entity conducting administrative services for business or possessing claims data, eligibility data, provider files, and other information relating to health care provided to Vermont residents or by Vermont health care providers and facilities." Section 3(X) further provides that the term "health insurer" also includes, "to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities."

Under the Regulation, "[h]ealth [i]nsurers shall regularly submit medical claims data, pharmacy claims data, member eligibility data, provider data, and other information" in accordance with the regulation's data submission requirements. Regulation H-2008-01, §4(D). (The Regulation elsewhere excludes denied claims from the submission requirement. *Id.* §5(A)(8).) The data submission requirements regulate, among other things, the content, coding, encryption, and file format of the data. *Id.* §5(A). The Regulation also includes detailed file specifications that dictate such minutiae as the placement of decimal points and the justification of text fields. *Id.* §5(B). Data must be submitted on a prescribed schedule, which varies from monthly to quarterly to annually, depending on the number of members living or receiving services in Vermont. *Id.* §6(I). Health insurers with fewer than 200 enrolled or covered members living or receiving services in Vermont are considered voluntary reporters and may, but are not required to, submit data for use in the database. *Id.* §§3(Ab), 3(As), 4(E), 6(I).

C. Liberty Mutual's Self-Insured Employee Medical Plan

Liberty Mutual Insurance Company is the administrator and named fiduciary of a welfare benefit plan (Plan) that Liberty Mutual established for the benefit of company employees. The Plan provides medical benefits to more than 30,000 employees of Liberty Mutual Group Inc. and its subsidiaries, as well as those employees' families and company retirees. As of June 30, 2011, the Plan provided medical benefits to 84,711 persons located in all 50 States. Pet. App. 50.

The Plan is self-funded, or self-insured, as Liberty Mutual pays all benefits provided under the Plan from its own assets. Pet. App. 50. Liberty Mutual uses a third-party administrator (TPA), Blue Cross Blue Shield of Massachusetts, Inc. ("Blue Cross") to handle processing, reviewing, and paying claims for Vermont participants in the Plan. *Id.* 8.

The Plan's governing documents provide that the "'Plan has been established for the exclusive benefit of Participants'" and that "'all contributions under the Plan may be used only for such purpose.'" Pet. App. 8. The Plan also represents that specified medical information that participants provide will be kept "'strictly confidential.'" *Id.* In addition, the contract between Liberty Mutual and Blue Cross requires Blue Cross to use information it receives from Liberty Mutual solely for purposes of administering the Plan and includes requirements directed at guarding against unauthorized disclosure of the information. *Id.* 51.

Both Liberty Mutual and Blue Cross are considered "health insurers" subject to Vermont's reporting requirements. Although Liberty Mutual has fewer than 200 participants or beneficiaries in Vermont and is

thus a voluntary reporter, Blue Cross is a mandatory reporter and must therefore report, for participants in the Plan, claims data in its possession. Pet. App. 54.

D. Proceedings Below

In 2011, Blue Cross received a subpoena demanding Liberty Mutual's medical and pharmacy claims files for use in Vermont's health care database. JA30-33. Liberty Mutual directed Blue Cross not to comply with the subpoena and filed a complaint in federal district court, seeking a declaration that ERISA preempts Vermont's reporting regime, to the extent it requires the reporting of claims information about participants in self-insured plans, and an injunction against enforcement of the subpoena. Pet. App. 9.

The district court ruled that Vermont's law and regulations are not preempted by ERISA. Pet. App. 61-79. A divided panel of the court of appeals reversed, and held that ERISA preempts Vermont's reporting requirements insofar as it requires the reporting of claims information about participants in self-insured plans. *Id.* 1-47.

For guidance, the court of appeals looked to this Court's test for ERISA preemption set forth in *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983): "[A] state law is preempted if 'it [1] has a connection with or [2] reference to [an ERISA] plan.'" Pet. App. 14 (emphasis omitted). The court observed that, in *Shaw*, this Court "treated as obvious that ERISA preempted 'state laws dealing with the subject matters covered by ERISA—*reporting*, *disclosure*, fiduciary responsibility, and the like.'" *Id.* (quoting *Shaw*, 463 U.S. at 98). And, the court explained, recent precedents have not changed two constants: "(1) recognition that ERISA's preemp-

tion clause is intended to avoid a multiplicity of burdensome state requirements for ERISA plan administration; and (2) acknowledgement that 'reporting' is a core ERISA administrative function." *Id.* 3-4.

Applying those principles, the court concluded that Vermont's reporting requirements are preempted as applied to ERISA plans because those requirements have a "'connection with' ERISA plans." Pet. App. 23. The court relied on the principle that "'reporting' is a core ERISA function shielded from potentially inconsistent and burdensome state regulation." *Id.* The court acknowledged that "[n]ot every state law imposing a reporting requirement is preempted" and that ERISA tolerates "laws that create no impediment to an employer's adoption of a uniform benefit administration scheme and with too tenuous, remote, or peripheral an effect on employee benefit plans." *Id.* 24 (internal quotation marks, citations and brackets omitted). But, the court stressed, Vermont requires the reporting of "information about the essential functioning of employee health plans." *Id.* 29 n.13.

The court also found preemption here to be necessary "to avoid proliferation of state administrative regimes" that would subject the Plan to overlapping and potentially conflicting requirements. Pet. App. 21. The court explained that "[a] hodge-podge of state reporting laws, each *more* onerous than ERISA's uniform federal reporting regime, and seeking different and additional data, is exactly the threat that motivates ERISA preemption." *Id.* 24 n.11. It thus concluded that the burden of Vermont's reporting requirements, when "considered as one of several or a score of uncoordinated state reporting regimes," was "obviously intolerable." *Id.* 25.

SUMMARY OF ARGUMENT

Vermont's laws are preempted because they have "a connection with" employee benefit plans. They require plans to report on activity that is at the core of what plans do—provide benefits.

I. A central objective of ERISA is to provide a uniform regulatory regime over plans, thereby minimizing the administrative burdens imposed on them and maximizing plan resources available to pay benefits. ERISA therefore includes an expansive preemption provision intended to ensure that plan regulation is exclusively federal. Reporting requirements are a key piece of ERISA's uniform regulatory regime.

The evolution of ERISA shows that Congress was acutely concerned that States would undermine the federal regime's uniformity and plan efficiency by imposing additional reporting requirements. Congress intended ERISA to relieve plans of the burden of multiple reporting obligations, forbidding States from requiring plans to report about the claims they pay.

II. Vermont's reporting requirements, as applied to ERISA plans, are fundamentally inconsistent with ERISA's objectives in at least three ways.

A. Vermont's requirements implicate an area of core ERISA concern: claims paid under an employee benefit plan. The obligation to report claims data arises from self-insured plans engaging in an essential plan function—providing medical benefits to participants. Vermont's regime is tied directly to a core function of an ERISA plan, distinguishing it from reporting obligations attendant to generally applicable state laws that are not directed at the core act of providing health care benefits. Vermont's law is therefore preempted, re-

gardless of whether the federal government currently requires disclosure of the same information.

B. Reporting requirements like Vermont's interfere with nationally uniform plan administration because they impose state-prescribed recordkeeping and reporting obligations that plans do not face in other States and that have not been imposed by the federal government. Those requirements depart from federal reporting requirements in terms of content, timing, and formatting, and they also differ widely across States. Congress, however, intended ERISA to protect plans from having to comply with 50 state reporting regimes.

C. Vermont's reporting requirements prevent the plan fiduciary from administering the plan in accordance with plan documents because they conflict with obligations the plan documents impose upon the Plan.

III. Preemption of Vermont's reporting requirements is not inconsistent with the objectives of federal statutes enacted after ERISA, nor are those statutes relevant to determining ERISA's purpose. Nor can Vermont's reporting requirements escape ERISA's reach as a generally applicable state health care regulation. The requirements target health care payers, not health care providers, and are very different from the types of state health care regulations that this Court has previously held to be free from ERISA preemption.

ARGUMENT

ERISA contains perhaps the broadest preemption provision in the United States Code. The federal law "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. §1144. That clause reflects a congressional intent that state laws must yield to ERISA if

they have "a connection with" ERISA plans, determined by looking "both to 'the objectives of the ERISA statutes as a guide to the scope of the state law that Congress understood would survive,' as well as to the nature of the effect of the state law on ERISA plans." *Egelhoff*, 532 U.S. at 147. Whatever might be said about the outer limits of "connection," that concept is satisfied in this case. ERISA preempts Vermont's attempt to bring self-insured benefit plans within its reporting regime.

Although petitioner seeks to paint Vermont's reporting requirements as tangential to Congress's concerns in ERISA, in fact one of Congress's principal objectives was to ensure that benefit plans would not have to face multiple, potentially conflicting, reporting requirements about payment of benefits. The preemption language in the disclosure law ERISA repealed was exceedingly narrow, expressly allowing States to supplement minimum federal reporting requirements with their own. ERISA's preemption language, in contrast, is exceedingly broad. And one of the most striking things about the evolution of ERISA in the legislative process was just how concerned Congress was with establishing a uniform federal reporting regime. Congress no longer wanted federal law to be a source of minimum reporting standards; it intended federal law to be the source of uniform standards. Congress enacted ERISA's broad preemption provision in part to make its federal reporting requirements exclusive.

Vermont's reporting requirements concern the core of what ERISA plans do. Vermont demands information about benefits that Liberty Mutual has paid under its employee welfare benefit plan. But providing benefits is what ERISA plans do every day; that is what makes them ERISA plans. Vermont's reporting

regime is not a generally applicable law concerning matters merely incidental to the provision of benefits.

Congress intended ERISA to establish a uniform regulatory regime that would allow self-insured plans to operate free from the burdens of state reporting obligations like the ones imposed by Vermont. Vermont's requirements directly implicate a core plan function (the payment of benefits under the Plan), interfere with nationally uniform plan administration, and conflict with the Plan's terms. The Vermont requirements are therefore preempted.

I. ERISA Preempts State Mandates To Report About Core ERISA Subject Matters

A. Congress Intended ERISA To Benefit Plan Participants And Beneficiaries By Minimizing Administrative Burdens Through A Uniform Federal Regulatory Regime

The parties agree that "[t]he principal object of [ERISA] is to protect plan participants and beneficiaries." *Boggs*, 520 U.S. at 845. How ERISA accomplishes that objective, however, is a complex matter, and petitioner presents a decidedly one-sided and incomplete picture. In part, ERISA protects plan participants and beneficiaries by imposing strong federal requirements to prevent the mismanagement of funds and the failure to pay benefits. But Congress also recognized that employees and beneficiaries would not benefit from plans that operated in an inefficient way, encumbered by costly administrative requirements. Congress did not want "a system that is so complex that administrative costs ... unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp.* v. *Howe*, 516 U.S. 489, 497 (1996).

Preemption of state law was central to Congress's objective of ensuring that plans operate efficiently. Congress wanted plan resources to be available for payment of benefits rather than administrative costs. Congress also wanted benefit plans to be free to operate nationally, without needing to comply with potentially conflicting state insurance regulation. "The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans." *Aetna Health Inc.* v. *Davila*, 542 U.S. 200, 208 (2004). The preemption clause is intended "to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government. Otherwise, the inefficiencies created could work to the detriment of plan beneficiaries." *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 142 (1990). Administrative costs, after all, are "ultimately borne by the beneficiaries." *Egelhoff*, 532 U.S. at 150.

Congress also enacted uniform requirements to encourage employers to establish employee benefit plans in the first place. This Court has repeatedly recognized that "ERISA 'induc[es] employers to offer benefits'" by assuring them a uniform set of regulations. *Conkright* v. *Frommert*, 559 U.S. 506, 517 (2010). Absent preemption, Congress understood, employers might be so deterred by the administrative burden and cost of complying with multiple state regulations that they might not set up an employee benefit plan at all.

B. ERISA's Uniform Regulatory Regime Includes Reporting

A major premise of petitioner's argument (joined by the United States) is that—notwithstanding this Court's repeated references to reporting and disclosure as core aspects of ERISA's uniform regulatory re-

gime—Congress was concerned with uniformity only as to fiduciary standards, substantive eligibility for plan benefits, and the mechanisms by which benefits are disbursed. Thus, petitioner argues, reporting about claims is tangential to ERISA, and the States are free to impose their own reporting requirements, even if those requirements are different from those imposed by the federal government (and different from State to State).

That argument is misguided. Congress made uniform reporting a key piece of ERISA's national regulatory regime. "Reporting and Disclosure" is the first of seven titular parts encompassing ERISA's "Regulatory Provisions." ERISA §§101-111, *codified as amended at* 29 U.S.C. §§1021-1031. The federal reporting requirements promulgated under ERISA, 29 C.F.R. Part 2520, are extensive.

This Court has repeatedly recognized that reporting by employee benefit plans is a core subject matter covered by ERISA. *See California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A.*, 519 U.S. 316, 330 (1997); *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 661 (1995); *Ingersoll-Rand*, 498 U.S. at 137; *FMC*, 498 U.S. at 58; *Fort Halifax*, 482 U.S. at 9; *Shaw*, 463 U.S. at 97. And the Court has stated repeatedly that ERISA's preemption provision encompasses state regulation of reporting by employee benefit plans. *See, e.g., Travelers*, 514 U.S. at 661; *FMC*, 498 U.S. at 58; *Shaw*, 463 U.S. at 98; *see also Fort Halifax*, 482 U.S. at 9 (suggesting that state regulations that required plans "to keep certain records in some States but not in others" would be preempted).

Petitioner and the United States suggest that this Court's language has been overinclusive, and that the only purpose Congress had for ERISA's reporting regime was to serve the related goals of preventing the mismanagement of funds and failure to pay benefits. Pet. Br. 36-38; U.S. Br. 15-16. But this Court's language has been precise and accurate. As explained below, Congress was concerned that States would undermine the uniformity of the regime governing ERISA plan functions and the efficiency of ERISA plans by imposing additional, potentially burdensome reporting requirements. For that reason, Congress preempted state laws that require *reporting* about benefits—not just state laws that regulate the benefits themselves.

C. Congress Intended To Preempt State Mandates To Report About ERISA Subjects, Including Claims

Federal legislation before ERISA established minimum, but not exclusive, reporting requirements for employee benefit plans. Congress began regulating employee benefit plans with the Welfare and Pensions Plans Disclosure Act (WPPDA), Pub. L. No. 85-836, 72 Stat. 997 (1958). *See Malone* v. *White Motor Corp.*, 435 U.S. 497, 506 (1978). That law established federal reporting standards—requiring plan administrators to annually report information such as "the number of employees covered" and "the amount of benefits paid or otherwise furnished," WPPDA §7(b), 72 Stat. 1000—but allowed States to supplement federal reporting requirements. Although the WPPDA shielded employers from duplicative *identical* state and federal reporting requirements, it included an anti-preemption clause stating that the federal requirements *did not* "prevent

any State from obtaining such additional information relating to any such plan as it may desire, or from otherwise regulating such plan." *Malone*, 435 U.S. at 505 (quoting WPPDA §10(a), 72 Stat. 1003).

Congress "came to quite a different conclusion in 1974 when ERISA was adopted." *Malone*, 435 U.S. at 512. ERISA repealed the WPPDA. *Id.* at 505 n.7. Congress's experience with benefit plans led it to conclude that a uniform federal law was essential to ensure that plans would operate efficiently, with resources inuring to the benefit of employees and beneficiaries rather than being drained for administrative costs. Congress's view about preemption evolved during the legislative process, but one thing never in doubt was that plans should be relieved of the burden of multiple reporting obligations.

ERISA's broad preemption provision originated as a narrower but more detailed provision specifically targeting state reporting requirements. As introduced in the House, the bill that became ERISA would have preempted state laws "relat[ing] to the fiduciary, *reporting, and disclosure responsibilities* of persons acting on behalf of employee benefit plans." *FMC*, 498 U.S. at 59 n.3 (quoting H.R. 2, 93d Cong., 1st Sess., §514(a) (1973) (emphasis added)). The House approved the bill in slightly modified form, preempting state laws "relat[ing] to *the reporting and disclosure responsibilities*, and fiduciary responsibilities, of persons acting on behalf of any employee benefit plan." *Shaw*, 463 U.S. at 98 n.18 (quoting H.R. 2, 93d Cong., 2d Sess., §514(a) (1973)).

The bill that was introduced in and passed the Senate did not expressly refer to "reporting," but it preempted state laws "relat[ing] to the subject matters

regulated by" the bill, *FMC*, 498 U.S. at 59 n.3 (quoting S. 4, 93d Cong., 1st Sess. §609(a) (1973)), and reporting was a regulated subject matter. The Senate committee report endorsing the bill, like the corresponding House committee report, made clear that the bill was intended to preempt state reporting laws. S. Rep. No. 93-127, at 35 (1973) ("Because of the interstate character of employee benefit plans, the Committee believes it essential to provide for a uniform source of law in the areas of vesting, funding, insurance and portability standards, for evaluating fiduciary conduct, and *for creating a single reporting and disclosure system in lieu of burdensome multiple reports.*" (emphasis added)); *see also* H.R. Rep. No. 93-533, at 17 (1974).

The Conference Committee replaced the House's reporting-specific preemption provision with the preemption provision in the current statute, thus adopting "significantly broadened" language, *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 745 (1985), with a broader preemption purpose, *FMC*, 498 U.S. at 58-59. This broader goal necessarily encompassed the more specific objective to preempt state reporting laws. As one Conference Committee member summarized: "In view of Federal preemption, State laws compelling disclosure from private welfare or pension plans ... will be superseded." 120 Cong. Rec. 29,942 (1974) (Sen. Javits).

The broad preemption provision was central to Congress's core objectives in ERISA, for it protected plans—and ultimately, plan participants and beneficiaries—from burdensome state requirements. Following the Conference, ERISA's principal House sponsor explained that preemption was "to many the crowning achievement of this legislation.... With the preemption of the field, we round out the protection afforded par-

ticipants by eliminating the threat of conflicting and inconsistent State and local regulation." *Shaw*, 463 U.S. at 99 (quoting 120 Cong. Rec. 29,197 (1974) (Rep. Dent)); *accord id.* (quoting 120 Cong. Rec. 29,933 (1974) (Sen. Williams)).

Preemption of state reporting requirements was essential to enactment of ERISA. Employee benefit plan reform resulted from a compromise in which business and labor interests accepted strong federal reporting and fiduciary standards in exchange for those federal standards being exclusive.[3] Preemption of state reporting requirements was always understood as a necessary part of the bargain. Beginning with the Nixon Administration's first proposal, which ultimately led to ERISA, *see Metropolitan Life*, 471 U.S. at 745 n.23, proposed employee benefits legislation had consistently included preemption of state reporting requirements. *See* S. 3589, 91st Cong., 2d Sess., §14, *in* 116 Cong. Rec. 7,284 (1970); *see also* 116 Cong. Rec. 7,286 (1970) (explanatory statement of Secretary of Labor) (bill provides for "a singular reporting and disclosure system in lieu of burdensome multiple reports"). Stakeholders emphasized the importance of uniform reporting requirements during the legislative hearings.[4]

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[3] *See* Wooten, *A Legislative and Political History of ERISA Preemption, Part 3*, 15 J. Pension Benefits 15, 19 (2008).

[4] *E.g.*, House Committee on Ways and Means, Written Comments Submitted by Interest Organizations and Individuals (Oct. 1, 1973) (C.R. Morgan) ("[L]egislation should provide a preemption of State law by the Federal law. The rapid expansion of conflicting State laws is creating an administrative jungle which requires a coordination of reporting requirements."), *in* 7 Legislative History of Employee Benefit Security Act, P.L. 93-406 [ERISA] (compiled by Covington & Burling LLP), at 783 (1974) ("Legislative History"); Senate Subcommittee on Private Pension Plans, Hearings on

Indeed, Members of Congress centrally involved in passing ERISA were acutely concerned about the administrative burden of *federal* reporting requirements.[5] They worried that the administrative burden of dual reporting to two *federal* agencies, the Treasury and Labor Departments, would ultimately harm plan beneficiaries.[6] The Secretary of the Treasury and Secretary of Labor agreed. They informed Congress that it was "essential to minimize the burdens placed on plan administrators by the numerous reporting requirements established under either the House or Senate bills" and recommended "consolidat[ing] all reporting require-

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Private Pension Plan Reform (June 4, 1973) (M.D. Furman) ("[C]ompliance with federal disclosure act reporting ... should preempt state law.... It seems far better to spend these funds on benefits rather than on the support of company pension plan administrators, state insurance and banking department employee administrators."), *in* 6 Legislative History 1162.

[5] *E.g.*, House Subcommittee on Labor, Hearings on Welfare and Pension Plan Legislation (Feb. 21, 1973) (Rep. Dent) ("I am going to be anxious to hear anything that will cut down on the burdensome job of reporting."), *in* 5 Legislative History 94; House Subcommittee on Labor, Hearings on Welfare and Pension Plan Legislation (Apr. 27, 1973) (Rep. Burton) ("We're troubled about the excessive reporting requirements."), *in* 5 Legislative History 689.

[6] *E.g.*, 120 Cong. Rec. 4,778 (1974) (Rep. Price) ("Some estimates indicate that for many small companies the administration costs will double, and those costs are already running up as high as 40 percent of the overall costs of the plans in some cases. Dual reporting could literally force some of these small company plans out of existence[.]"); 120 Cong. Rec. 4,442 (1974) (Rep. Archer) ("I do take issue with the question of the cost to the employer which in effect becomes the cost of the worker for administration. If we have in effect provided all of these fine safeguards but the cost of providing reports in complying with all of the regulations of two Federal agencies, which might and probably will be conflicting, then we have undone all the good safeguards.").

ments into a single report" that was "simple and efficient from the standpoint of plan administrators." Administration Recommendations to the House and Senate Conferees on H.R. 2 (Apr. 1974), *in* 3 Legislative History of the Employee Retirement Income Security Act of 1974 (Committee Print prepared by the Senate Subcommittee on Labor), at 5127-5128 (1976); *see also id.* at 5131 (noting that uniform "form and detail" requirements, prescribed by one agency, were necessary to create "order in the reporting area, from the viewpoints of both the Labor Department and plan administrators").

The legislation, as ultimately enacted, responded to those concerns by directing federal agencies to avoid duplicative reporting requirements. *See* 29 U.S.C. §1204(a) (Treasury and Labor Departments "shall develop rules, regulations, practices, and forms which ... are designed to reduce duplication of effort, *duplication of reporting*, conflicting or overlapping requirements, *and the burden of compliance with such provisions by plan administrators, employers, participants and beneficiaries*" (emphasis added)). The Conference Report explained that the federal government was to reduce duplication and the burden of compliance "to the maximum extent practical." H.R. Conf. Rep. No. 93-1280, at 360 (1974).

Given Congress's mandate that the federal government reduce the burden on plans of complying with just two federal agencies' reporting requirements, it is inconceivable that Congress would have allowed each of the 50 States to impose its own reporting requirements as well. Congress would not have prohibited duplicative reporting by the Treasury and Labor Departments only to allow States to thwart that prohibition through their own reporting requirements.

Moreover, Congress clearly understood that reporting about claims, like other reporting about core plan functions, could impose serious administrative burdens on plans. Congress was familiar with mandates to report information about claims from the WPPDA, which required plan administrators to file an annual report containing information including "the number of employees covered" and "the amount of benefits paid or otherwise furnished" for the year. WPPDA §7(b), 72 Stat. 1000. The original House and Senate bills that became ERISA would have likewise required plan administrators to annually report "the number of employees covered" and "the amount of benefits paid or otherwise furnished." H.R. 2, 93d Cong., 1st Sess., §104(b)(1); S. 4, 93d Cong., 1st Sess. §506(d). Concerned about administrative burden, Congress ultimately amended the bills to reduce their reporting requirements, choosing not to require plan administrators to report the amount of benefits paid. But Congress did require plans that use third-party insurance rather than self-insuring to report the total amount of claims paid by the insurer. *See* 29 U.S.C. §1023(e)(2).

The evolution of ERISA refutes petitioner's contention that Congress was unconcerned about claims reporting when it preempted state laws. To the contrary, Congress clearly considered claims information to be part of the reporting encompassed within ERISA and knew how to require claims reporting when it wanted to require that data. Congress also understood that reporting about claims could be extremely burdensome on plans, and it made the considered decision to relieve plans of the burden of filing duplicative—much less multiplicative—reports on that subject. Given Congress's detailed attention to claims reporting, it cannot be seriously maintained that reporting about

claims paid by an employee benefit plan is anything other than a core function of that plan. ERISA's preemption clause therefore forbids States from requiring ERISA plans to report about the claims that they pay.

II. Vermont's Reporting Requirements Interfere With Congress's Design Of Uniform Regulation In An Area Of Core ERISA Concern

Congress's central concern in enacting ERISA's preemption clause was ensuring that plans could operate nationally, efficiently, and for the benefit of employees and beneficiaries without the burden and expense of complying with multiple, potentially conflicting state law requirements. Vermont's reporting regime, as applied to ERISA plans, is inconsistent with that congressional design. *First*, Vermont's reporting requirements implicate an area of core ERISA concern: benefits paid under an employee benefit plan. *Second*, the requirements interfere with nationally uniform plan administration, considered by themselves or as part of the burgeoning set of disparate reporting obligations being mandated by the States. *Third*, they prevent the plan fiduciary from administering the plan in accordance with the plan documents.

A. Vermont's Reporting Requirements Implicate A Core Subject Matter Covered By ERISA

1. Vermont requires reporting about the core functions of self-insured ERISA plans

Vermont's reporting requirements are directly connected to an activity that is the essence of an employee welfare benefit plan under ERISA: self-insured plans' provision of health care benefits to their employ-

ees. That characteristic of Vermont's requirements distinguishes them from other state laws that may impose reporting requirements on ERISA plans but are not subject to preemption under ERISA.

a. The provision of employee benefits is a defining characteristic of an ERISA plan. ERISA defines an employee welfare benefit plan to include "any plan, fund, or program ... [that provides] its participants or their beneficiaries, through the purchase of insurance or otherwise, ... medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, [or] death." 29 U.S.C. §1002(1). Courts regularly look to the circumstances surrounding an employer's provision of benefits to its employees to determine whether an employee benefit plan has been established under ERISA. *E.g.*, *Okun* v. *Montefiore Med. Ctr.*, 793 F.3d 277, 279 (2d Cir. 2015).

Here, data from employee benefit plans become subject to Vermont's reporting requirements because those plans are engaging in their essential function of paying benefits. Vermont's reporting regime applies to "entities that pay for health care services provided to Vermont residents" (Pet. Br. 10) and requires those entities to provide "claims data." The regime clearly targets plans' provision of health benefits to plan members and is directly tied to that core plan function. Under these circumstances—where a State requires reporting because a self-insured employee health plan is engaged in the very activity that defines it as a self-insured employee health plan—the state law necessarily has a connection with the plan and is preempted.

b. Petitioner seeks to avoid preemption here by listing the various kinds of data that it presently does *not* include within its reporting requirements, such as

information on denied claims. Pet. Br. 44. But Vermont does not disclaim the authority to apply its regime more broadly, to encompass denied claims as well as a great deal of other information about plan benefits, and the wording of the Database Statute suggests it may ultimately do so. The statute is sweeping; it requires covered entities to report their "health insurance claims data," not merely information about paid claims. *See* 18 V.S.A §9410(h)(1)(A); *see also id.* §9410(c)(1) (requiring reporting of "health insurance claims and enrollment information used by health insurers"). Although Vermont regulators for the moment have decided not to request information about denied claims, nothing in the Database Statute prevents them from seeking that information in the future. And other States that are developing similar databases do require information on denied claims. *See infra* pp. 35-36.

In any event, what Vermont *has* required—the reporting of data on claims paid under self-insured plans—is directly connected to the core activities of an ERISA plan. Because it is the payment of health benefits—a core function of a self-insured employee health plan—that leads to the requirement to report claims data to Vermont, the connection required for ERISA preemption is plainly present.

2. Vermont's reporting law is preempted even though the federal government does not currently require disclosure of the same information

Petitioner and the United States argue that ERISA does not preempt Vermont's reporting regime because the reporting requirements in Vermont's law and in ERISA serve different purposes. Pet. Br. 36-39;

U.S. Br. 10-11, 15-19. They contend that the reporting requirements in ERISA were enacted to protect plan beneficiaries from fiduciary mismanagement and that Vermont's reporting regime does not relate to that purpose. That position suffers from severe flaws.

a. First, there is no basis to petitioner's and the United States' assumption that Congress intended to reserve for exclusive federal authority only those reporting requirements concerning fiduciary mismanagement. No such distinction appears in the text of ERISA, which recognizes the Secretary of Labor's broad authority to impose reporting requirements on plans, including requirements beyond what would be necessary to protect plan beneficiaries from fiduciary mismanagement. *See* 29 U.S.C. §1024(a)(2)(B) ("Nothing contained in this paragraph shall preclude the Secretary from requiring any information or data from any such plan to which this part applies where he finds such data or information is necessary to carry out the purposes of this subchapter").[7] And ERISA by its terms "supersede[s]" "any and all" state laws relating to employee benefit plans, not just state laws relating to the fiduciary aspects of plan management.

Moreover, the United States appears to take the position that it *does* have the power to impose claims

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[7] In addition, under 29 U.S.C. §1143(a)(1), the Secretary has the authority "to undertake research and surveys and in connection therewith to collect, compile, analyze and publish data, information, and statistics relating to employee benefit plans." Further, some plans are subject to claims reporting requirements under ERISA; plans that purchase third-party insurance must report the total claims paid by the third-party insurer. *Id.* §1023(e)(2).

reporting requirements on self-insured ERISA plans.[8] At the petition stage, the United States represented that the Secretary of Labor—"in aid of his authority to ensure compliance with ERISA's fiduciary standards and claims processing rules"—"is currently considering undertaking a rulemaking to require health plans to report more detailed information about the cost of benefits, *utilization of medical services*, and plan administration." CVSG Br. 3 n.1 (emphasis added). The United States has reaffirmed its position in its merits brief, noting that the Secretary of Labor, "pursuant to the authority granted by ERISA and the [Affordable Care Act (ACA)], ... is currently considering a rulemaking to require health plans to report more detailed information about various aspects of plan administration, such as enrollment, claims processing, and benefit offerings." U.S. Br. 4.

Although the contours of this proposed rulemaking remain unclear, at no point in this case—either before the court of appeals or before this Court—has the United States denied that the Labor Department would have the power under ERISA to impose on self-insured plans the exact same claims reporting requirements that Vermont has enacted.[9] And if—as the

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[8] Even if ERISA did not grant the Labor Department the authority to impose claims reporting requirements, then Congress's decision not to grant that authority, coupled with ERISA's preemption provision, would represent Congress's determination that ERISA plans should remain free from those kinds of requirements at both the federal and the state levels. *See Arkansas Elec. Coop. Corp.* v. *Arkansas Pub. Serv. Comm'n*, 461 U.S. 375, 383-384 (1983).

[9] The United States asserts that the ACA establishes new reporting requirements applicable to group health plans but that those requirements "would not fill the void left by invalidating

United States also does not deny—such federal reporting requirements, once enacted, *would* preempt additional state reporting requirements, then it is hard to see why those state requirements are not preempted now. ERISA preempts *all* state laws relating to employee benefit plans, not just state laws relating to plans once the Labor Department has enacted a regulation covering the same subject. Otherwise preemption could expand and contract like an accordion, depending on the policy preferences of the Labor Department at any particular time.

Nor does it matter that ERISA allows the Secretary of Labor to exempt welfare benefit plans from "all or part of the reporting and disclosure requirements" of the law or to require only simplified reporting from welfare plans, 29 U.S.C. §1024(3), and that the Secretary has exercised that authority for certain welfare plans, *see* U.S. Br. 2. The scope of ERISA's preemption of *state* reporting and disclosure requirements cannot turn on which *federal* reporting requirements the Labor Department has until now seen fit to enforce. The fact that the Labor Department has chosen to exempt certain plans from some of ERISA's reporting requirements does not mean that Congress intended for welfare benefit plans to be subject to 50 States' reporting laws. Indeed, the Labor Department's decision not to impose burdensome reporting requirements on certain employee welfare benefits plans is itself a regulatory choice that should not be upset by the application of state reporting requirements. *See Arkansas Elec.*

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state-level efforts to compile databases of healthcare-expenditure information across the board." U.S. Br. 21-22. The United States, however, does not disclaim the position that ERISA gives it the authority to require claims data from welfare benefit plans.

Coop. Corp. v. *Arkansas Pub. Serv. Comm'n*, 461 U.S. 375, 383-384 (1983).

Moreover, the position taken by petitioner and the United States is not compatible with this Court's recognition that preemption is not limited to state laws specifically dealing with the subject matters covered by ERISA. ERISA does not need to speak specifically to a subject for a state law addressing that subject to "relate to" an employee benefit plan under §1144(a). *See FMC*, 498 U.S. at 58-59 (observing that interpreting the preemption clause "to apply only to state laws dealing with the subject matters covered by ERISA" would be incompatible with Congress's intent); *cf. Shaw*, 463 U.S. at 96-97 (holding that a state anti-discrimination statute "relates to" an employee benefit plan even though ERISA "does not mandate that employers provide any particular benefits, and does not itself proscribe discrimination in the provision of employee benefits"). Congress intended ERISA plans to be subject to one set of regulations, and state intrusion into this area is prohibited even if state regulation does not require something the federal government forbids, or vice versa.

b. More generally, petitioner and the United States err by attempting to distinguish between the purpose of the state law and the federal regulations. A state law—even one with a noble purpose—is preempted if its *effects* conflict with Congress's objectives in ERISA. A state law does not avoid preemption simply because it was enacted for a purpose different from the purposes underlying ERISA's requirements.

This Court's broader preemption jurisprudence makes this point clear. For example, the Court rejected the argument that the Occupational Safety and Health Act (OSHA) would lose its preemptive force if

"the state legislature articulates a purpose other than (or in addition to) workplace health and safety." *Gade* v. *National Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 105 (1992). The Court noted that it would defeat the purpose of OSHA "if a state could enact measures stricter than OSHA's and largely accomplished through regulation of worker health and safety simply by asserting a non-occupational purpose for the legislation." *Id.* at 106. It concluded that, "[w]hatever the purpose or purposes of the state law, pre-emption analysis cannot ignore the effect of the challenged state action on the pre-empted field." *Id.* at 107; *see also id.* at 106 ("[P]re-emption analysis turns not on whether federal and state laws 'are aimed at distinct and different evils' but whether they 'operate upon the same object.'"). Similarly, this Court has rejected the notion "that state law may frustrate the operation of federal law as long as the state legislature in passing its law had some purpose in mind other than frustration." *Perez* v. *Campbell*, 402 U.S. 637, 651 (1971).

The Court's observations in *Gade* and *Perez* illustrate why the position taken by petitioner and the United States is untenable. Vermont may have had a benign objective in deciding to construct a claims database, but the *effect* of the application of its Database Statute is to require the reporting of data about payment of claims—a core plan function—that Congress determined should be imposed by the federal government, or not at all. That forbidden effect is sufficient for preemption.

B. Vermont's Reporting Requirements Interfere With Nationally Uniform Plan Administration

1. State claims reporting requirements depart from federal standards and differ widely

a. ERISA preempts state laws that "interfere[] with nationally uniform plan administration." *Egelhoff*, 532 U.S. at 148. Vermont's reporting requirements interfere with uniform administration of employee benefit plans because they impose recordkeeping and reporting obligations on the plans that apply only to the plan's reporting of Vermont-related claims, obligations that the federal government has not imposed and that plans do not face in other States. *See id.* ("Uniformity is impossible ... if plans are subject to different legal obligations in different States.").

The court of appeals catalogued several of those "myriad," "burdensome," "time-consuming" requirements. Pet. App. 25-27. They govern content, requiring extensive data about medical claims, pharmacy claims, member eligibility, and other information that differs from the data the federal government requires. *See* Regulation H-2008-01 §§4-5. They govern timing, requiring plans to report their data monthly, quarterly, or annually, even though ERISA contemplates only a single report annually. *Compare id.* §6 *with* 29 U.S.C. §1021.

Vermont's regulations also impose detailed coding and formatting obligations that have no federal parallel. *See* Regulation H-2008-01 §5. Petitioner's amici argue that Vermont's regulations impose "no new or unique recording-keeping" requirements for data beyond what HIPAA already requires. NAHDO Br. 5-11. But Vermont's regulations show otherwise. Their appen-

dices outline numerous data elements that Vermont requires for which there is no parallel HIPAA standard, including, among many others: Member Suffix or Sequence Number, Date Service Approved, Coinsurance Amount, Deductible Amount, Prepaid Amount, Co-pay Amount, Discharge Date, National Billing Provider ID, and encrypted information identifying the subscriber and member.[10]

Vermont's regulations thus require state-specific processing of records and reporting, obligating plans to provide state-prescribed information in a state-prescribed format and at state-prescribed intervals on state-specified claims paid by the plan. The requirements call for different information, at different intervals, and in a different format than the federal government requires. They contradict ERISA's objective that plans should not be "required to keep certain records in some States but not in others." *Fort Halifax*, 482 U.S. at 9. And their state-specific requirements preclude plans from accomplishing ERISA's overarching goal of establishing a nationally uniform administrative scheme.

Petitioner and the United States do not dispute that Vermont's reporting scheme obligates plans to process records for and report information about claims in Vermont that the plan is not obligated to do for other

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[10] *See* Regulation H-2008-01, Apps. C2, D2, & E2, *available at* http://www.dfr.vermont.gov/sites/default/files/REG-H-08-01.pdf (mapping Vermont's required data elements to national standards and denoting "N/A" where there is no applicable national standard); *see also* VHCURES Data Submission Guide 33, 41, 56 (July 2015), *available at* http://www.onpointhealthdata.org/clients/vhcures/docs/onpoint_vhcures_dsg_v20.pdf (providing descriptions of Vermont's required data elements "that lack a national standard altogether").

States. They nonetheless argue that Vermont's scheme is not preempted because any interference with uniform plan administration "does not intrude on any core ERISA function," Pet. Br. 45, or "prescribe binding rules for a central matter of plan administration," U.S. Br. 24. That argument is incorrect for the reasons explained above: Recording and reporting about claims paid is a core ERISA function—a central matter of plan administration. *See supra* pp. 25-31.

b. Moreover, Vermont's reporting regime cannot be considered in isolation. If Vermont is allowed to impose claims reporting requirements on a self-insured plan, then presumably every other State can do so as well, even though each State might decide to require different information, reported at different intervals, and submitted in different formats. But the danger of state regulation of ERISA plans that Congress foresaw was that each State might impose different requirements on nationally operating plans, and that plans would have to expend resources in complying with those varying requirements that would otherwise be available for benefits. *See Egelhoff*, 532 U.S. at 149-150 ("Requiring ERISA administrators to master the relevant laws of 50 states ... would undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately borne by beneficiaries."). "Thus, where a 'patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation,' [this Court has] applied the pre-emption clause to ensure that benefit plans will be governed by only a single set of regulations." *FMC*, 498 U.S. at 60.

That danger is plainly present here. The burdens that plans face from meeting conflicting state reporting requirements are significant. Although all-payer claims

database (APCD) statutes are relatively new—the first were enacted barely a decade ago—18 States have already enacted statutes that mandate reporting of claims data. *See* N.Y. Br. 1 n.1; NGA Br. 8 n.9. As the court of appeals recognized, state data submission requirements vary significantly. Pet. App. 7.

APCD statutes vary in whether they require reporting of denied claims. Although petitioner emphasizes that Vermont currently requires only information on paid claims, Pet. Br. 11, Oregon requires reporting of denied claims and other "encounter[s]."[11] Massachusetts does not yet require reporting of wholly denied claims, but does require reporting of a denied procedure encompassed within a paid claim, and has announced that it will require reporting of wholly denied claims.[12] Arkansas law authorizes compulsory reporting of denied claims, but regulators have not yet imposed that requirement.[13] Connecticut also does not

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[11] Or. Admin. R. 409-025-0100(12); *see* Oregon Health Authority, Memorandum to Mandatory Reporters 3 (Feb. 1, 2015), *available at* http://www.oregon.gov/oha/OHPR/rulemaking/notices/409-025_Appendices%20A-G.pdf ("Each submission shall include final claims (paid, *denied*, or *encounter only*)[.]" (emphasis added)).

[12] 114.5 Mass. Code Regs. 21.03(3)(b)(1)(a); *see* Massachusetts Center for Health Information and Analysis (CHIA), Massachusetts APCD Medical Claim File Submission Guide 4-5 (Oct. 2014), *available at* http://www.chiamass.gov/assets/docs/p/apcd/submission-guides/apcd-medical-claim-file-submission-guide.pdf ("Wholly denied claims are not submitted to CHIA. However, if a single procedure is denied within a paid claim that denied line is reported."); *id.* at 10 (CHIA will provide notice "when the requirement to submit [wholly] denied claims will become effective").

[13] *Compare* Ark. Act 1233, Proposed Rule 100 §4(18) (reportable data includes "all paid and denied claims"), *available at* http://insurance.arkansas.gov/Legal/PropRules/PropRule100.pdf, *with* Arkansas APCD Data Submission Guide 3 (Sept. 18, 2015),

currently require reporting of denied claims but has not "rule[d] out a future change in such policy," despite recognizing that the "[c]omplexities surrounding the capture and interpretation of denied claims" are "very challenging."[14]

APCD statutes vary in the kinds of claims they require to be reported. Vermont and Rhode Island do not require reporting of dental claims, but the four other New England States do.[15] APCD statutes also vary in the kinds of information they require. Massachusetts, for example, requires information on plan premiums, actuarial assumptions underlying those premiums, summaries of plan designs, medical and administrative expenses, reserves and surpluses, and provider payment methods and levels.[16]

APCD statutes vary in when reporting is required. Some States, like Vermont, require reporting based on the number of persons covered (with varying numbers),[17] others do so based on total dollars of claims

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available at https://www.arkansasapcd.net/Docs/64 ("Denied claims are not required for the APCD at this time.").

[14] Connecticut Health Insurance Exchange, Report on Public Comments, Policies and Procedures 1 (Nov. 1, 2013), *available at* http://www.ct.gov/hix/lib/hix/APCD_Policies_and_Procedures_Public_Comment_Report.pdf.

[15] *Compare* Regulation H-2008-01, §4(D), *and* Rhode Island Department of Health, APCD Project, *available at* http://www.health.state.ri.us/partners/collaboratives/allpayerclaimsdatabase (last visited Oct. 13, 2015), *with* Conn. Gen. Stat. §38a-1091(a)(1); Me. Code R. tit. 90-590 ch. 243 §2(A), 114.5 Mass. Code Regs. 21.03(3)(b)(3), *and* N.H. Code Admin. R. Ins. 4006.03.

[16] 114.5 Mass. Code. Regs. 21.03(2)(a).

[17] Regulation H-2008-01, §3(Ab) (200 members); *e.g.*, Or. Admin. R. 409-025-0110(1)(a)(C) (5,000 lives); Utah Admin. Code R. 428-2-10(5) (2,500 residents).

paid,[18] and still others based on market share.[19] Some States require monthly reporting,[20] others quarterly,[21] and still others, like Vermont, require monthly, quarterly, or annually reporting depending on the number of state residents for which the reporter has claims.[22] And APCD statutes differ in how information must be reported. For example, in 2011, five States, including Vermont, were collecting direct patient identifiers, five States prohibited collection of direct patient identifiers, and still others allowed collection of that information but had not yet begun collecting it.[23] That variation persists: Currently, about half of state APCDs require data without patient identifiers for privacy and security purposes, but the other half require data with patient identifiers to allow researchers to link APCD data with clinical data analysis.[24]

These variations create substantial compliance burdens—exactly what ERISA prohibits. Plans must familiarize themselves with the reporting requirements in each State and report different content, on different

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[18] *E.g.*, Minn. R. 4653.0100(8) ($3,000,000 in annual claims).

[19] *See* APCD Council, APCD Development Manual 50 (Mar. 2015), *available at* https://www.apcdcouncil.org/manual (one percent market share in Kansas).

[20] *E.g.*, 114.5 Mass. Code Regs. 21.03(4)(b); Utah Admin. Code R. 428-15-3.

[21] *E.g.*, Md. Code Regs. tit. 10, §25.06.05.

[22] Regulation H-2008-01, §6(I); *e.g.*, Me. Code R. tit. 90-590 ch. 243, §3(F).

[23] APCD Council, APCDs 2.0: The Next Evolution 5 (July 2011), *available at* https://www.apcdcouncil.org/publication/apcd-20-next-evolution.

[24] APCD Council, APCD Development Manual 34.

schedules, in different formats. States also change what data they require and how they want it reported, setting out these requirements in elaborate regulations and separate data submission guides.[25] State data submission guides are not always even consistent with state regulations. Petitioner, for example, emphasizes that Vermont's regulations currently do not require reporting of denied items within a partially paid claim. *See* Regulation H-2008-01, §5(A)(8); *see also* JA129 (Vermont Frequently Asked Questions (FAQ) No. 4) ("[C]laims with mixed covered and non-covered services will include only the service lines for the covered services."). Vermont's submission guide, however, instructs: "All lines of partially denied claims are to be reported. Only fully denied claims are to be excluded." VHCURES Data Submission Guide 41.

Moreover, the same claim is often subject to multiple reporting requirements. When a claim has a nexus to more than one State—such as an employee who resides in one State, works in another State, and receives medical services in a third—plans may be required to report that same claim in different ways, at different times, to different States. *Cf. Egelhoff*, 532 U.S. at 149. Indeed, Vermont's reporting regime recognizes the reporting complications for companies that engage in interstate commerce and therefore have employees who may change state residence over time. *See* JA138-139 (Vermont FAQ No. 23).

Plans are therefore not just faced with dual reporting between two federal agencies, which ERISA discourages, or even between one State and the federal

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[25] *See, e.g.*, VHCURES Data Submission Guide 41, 45, 56, 59 (noting change in reporting data on a member's relationship to the insured).

government, which ERISA prohibits. They are currently faced with reporting to 18 States, a number certain to grow, further increasing administrative expenses. This checkerboard system of regulation is directly contrary to Congress's intent that ERISA plans should operate and be administered on a uniform national basis.

c. Some amici argue that state claims reporting requirements present no threat to national uniform plan administration because (they say) the reporting requirements are standardized and not burdensome. *E.g.*, NGA Br. 9-10, 14-15, 17-18; AHA Br. 20-21; NAHDO Br. 11-16. To the contrary, the state reporting laws on their face vary in terms of the content required, timing, and other procedures. *See supra* pp. 35-37. The materials amici cite also refute their own contentions.

Petitioner's amici point to materials drafted by amicus APCD Council, including a fact sheet on "Standardization of Data Collection in APCDs." *E.g.*, NGA Br. 9-11, 15 & n.26; AHA Br. 22; NAHDO Br. 13. That fact sheet, which is in the record,[26] makes clear that state reporting requirements are far from uniform. It recognizes that "currently each state is collecting different data by different methods and with different definitions. *This non-uniform approach to developing APCDs* is limiting the ability to share analysis and applications across states, and *is raising costs for payers submitting data to the states (especially those payers that are operating in multiple states).*" JA219 (emphasis added). It also recognizes that payers follow their own administrative schemes and that data submission is not standardized. JA220 ("Because payers each use

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[26] The original is available at https://www.apcdcouncil.org/standards.

unique systems to administer their business, the challenges for payers to provide the required data vary."). It recognizes that payers must "allocate programming resources and funding" to comply with state reporting requirements and therefore need at least six months' notice to comply with any new ones. JA221. And it recognizes that the cost of complying will only continue to grow: *"As APCDs are required in more states, the cost to payers will become significant."* JA220 (emphasis added).[27]

Amici suggest that state reporting requirements will become more uniform in the future because the APCD Council has proposed model legislation. *E.g.*, NGA Br. 10 & n.14, 18, 25-26; AHA Br. 9; NAHDO Br. 14. Even setting aside that ERISA does not permit a dual set of federal requirements and uniform state requirements, that point is unpersuasive; States are not bound to standardize reporting requirements or to enact model legislation. Preemption analysis does not turn on whether the States might converge on a uniform regime. To the contrary, if state laws are not preempted, then presumably the States are free to experiment with different approaches.

Moreover, the model legislation amici invoke is not actually intended to be uniform. The introduction to the APCD Council's model legislation acknowledges: "While the model legislation can be used by states to guide APCD development, it is important to note that legislation differs from state to state based on the needs of the state, the laws of the state, the politics at the time

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[27] The APCD Council's most recent publications continue to highlight the "technical and financial burden to the payers associated with data submission." APCD Council, APCD Development Manual 18.

of passage, and the policy basis for the data collection itself." APCD Council, Model APCD Legislation 2 (May 2015), *available at* https://www.apcdcouncil.org/publication/model-all-payer-claims-database-legislation. The model legislation is only "intended to offer guidance, and states will need to modify and supplement the template language in the model legislation to reflect the specific intent and design of the APCD program and to reflect existing state law.... Each state should consider the laws of its state and the needs of its own citizens, thereby adapting its legislation accordingly." *Id.*

If anything, the APCD Council's materials underscore that state reporting requirements threaten uniform federal regulation of ERISA plans. The APCD Council has proposed that States require premium and benefit information, including "co-payments, coinsurances, deductibles, out-of-pocket maximums, lifetime maximums, and detailed medical or pharmacy benefits." APCD Council, APCDs 2.0, at 7-9. And it has noted that already "[m]any states have explored the prospect of expanding the APCD beyond information captured from claims payment systems" to include "plan benefit design" and "premium information." APCD Council, APCD Development Manual 62. Massachusetts, for example, has enacted a regulation requiring "All Private Health Care Payers," including "self-insured plans," to provide information on premiums, actuarial assumptions, summaries of plan designs, medical and administrative expenses, reserves and surpluses, and provider payment methods and levels. 114.5 Mass. Code Regs. 21.03. ERISA, however, already requires plans to file a summary plan description, a self-insured plan's actuarial basis, the premiums the plan collects, and information on many other features of

self-insured plans. *See* 29 U.S.C. §§1021, 1022, 1023, 1024, 1026; 29 C.F.R. Part 2520.

The APCD materials show that, if Vermont's claims reporting requirements are upheld, nationally operating self-insured plans may have to meet numerous differing, even conflicting, state mandates. That result would be directly contrary to Congress's judgment that plans should not be subject to such administrative burdens and that reporting requirements are exclusively the federal government's realm.

2. Liberty Mutual was not required to quantify the cost of complying with Vermont's reporting mandate

Petitioner and the United States argue that Liberty Mutual has failed to show that Vermont's reporting requirements interfere with nationally uniform plan administration because it did not quantify the administrative cost of compliance. Pet. Br. 54-55; U.S. Br. 28-29. They are wrong. ERISA's objective was to "eliminat[e] the *threat* of conflicting or inconsistent State and local regulation." *Fort Halifax* , 482 U.S. at 9 (quoting 120 Cong. Rec. 29,933 (1974) (Sen. Williams)) (emphasis added); *see also Ingersoll-Rand*, 498 U.S. at 142 ("Particularly disruptive is the *potential* for conflict in substantive law." (emphasis added)). The "threat" that States could enact different reporting requirements suffices to establish preemption. *See Egelhoff*, 532 U.S. at 148.

This Court has never suggested, let alone held, that a plan must quantify the administrative costs imposed on it—and passed onto its participants and beneficiaries—to show that a state mandate interfered with uniform plan administration. *See Egelhoff*, 532 U.S. at 148-150; *Ingersoll-Rand*, 498 U.S. at 142. Nor has the

Court rested its judgments in favor of preemption on the specific cost of compliance with a state mandate. Moreover, the concern animating preemption is not just the burden imposed by Vermont's requirements but the potential burden that the Plan would face if it had to comply with as many as 50 potentially conflicting reporting requirements of a similar nature—a number that could not be quantified at this point. Liberty Mutual was not required to prove the cost of complying with Vermont's reporting mandate, nor to quantify the cost of complying with the 18 current state reporting mandates, nor to speculate about how much the cost of compliance will be if and when all 50 States impose reporting mandates.

Petitioner and the United States nevertheless suggest that Liberty Mutual had to prove that the burdens created by Vermont's reporting requirements were so acute "as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers." Pet. Br. 28 n.15 (quoting *De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 816 n.16 (1997)); U.S. Br. 27. That argument does not reflect a fair reading of the footnote in *De Buono*, which discussed the circumstances under which preemption might occur as a result of the indirect economic effects of a law that addressed an area *outside* ERISA's core subjects. The Court was not addressing the standard for preemption where, as here, a state law imposes direct administrative burdens on a core ERISA subject. Since *De Buono*, this Court has made clear that state laws imposing that effect are preempted because they threaten uniform plan administration. *Egelhoff*, 532 U.S. at 150. Vermont's reporting requirements have that impermissible effect.

C. Vermont's Mandates Conflict With ERISA's Requirement That A Plan Be Administered In Accordance With Plan Documents

1. ERISA also preempts Vermont's reporting requirements as applied to Liberty Mutual's self-insured plan because they interfere with the Plan's relationships with its members and its third-party administrator. The documents governing the Plan obligate it to keep many medical records strictly confidential. The Plan's agreement with its third-party administrator also requires that its members' medical information be used solely for the purpose of plan administration. The Plan has made those commitments to its members to ensure that their health information will be used only to the extent necessary to provide their health benefits under the plan.

By impairing those obligations, Vermont's reporting requirements conflict with ERISA's commands that a plan "shall" be administered "in accordance with the documents and instruments governing the plan." 29 U.S.C. §1104(a)(1)(D). Vermont makes the data it collects from ERISA plans "available as a resource for insurers, employers, providers, purchasers of health care, and state agencies." 18 V.S.A. §9410(h)(3)(B). Although the Vermont regime includes confidentiality protections, it nonetheless affects the documents governing Liberty Mutual's ERISA plan by "impair[ing] or (at least) reassign[ing] the obligation in the Plan documents to keep medical records strictly confidential, as well as the undertaking by Blue Cross as [third-party administrator] to use information solely for Plan administration purposes and to prevent unauthorized disclosure." Pet. App. 27. The Vermont requirements make it impossible for Liberty Mutual or Blue Cross to administer the Plan in accordance with the plan docu-

ments and are therefore preempted. *See Egelhoff*, 532 U.S. at 151.

2. The United States argues that the reporting requirement's impact on the documents governing the Plan is irrelevant. U.S. Br. 32-34. Its arguments lack merit.

First, the United States attempts to minimize *Egelhoff* by claiming that nothing in that decision "supports the view that a state law that is otherwise *not* preempted could be circumvented by a contrary term in a particular plan." U.S. Br. 33-34. But what made the statute in *Egelhoff* preempted was that the statute imposed a set of rules for determining beneficiary status that would have required administrators to pay benefits to the beneficiaries chosen by state law, "rather than to those identified in the plan documents." 532 U.S. at 147. The Court held that the statute thus ran counter to, among other things, ERISA's command that the fiduciary shall administer the plan in accordance with the documents and instruments governing the plan. *Id.* *Egelhoff* thus stands for the proposition that a state law that reassigns obligations contained within the documents and instruments governing an ERISA plan necessarily "relates to" the ERISA plan and is preempted.

Second, although the United States contends that this Court rejected "a materially identical argument" in *UNUM Life Insurance Co. of America* v. *Ward*, 526 U.S. 358 (1999), it misapprehends the holding of *UNUM* and its relationship to this case. In *UNUM*, an insurance company argued that a state law that fell within ERISA's savings clause for state insurance regulations, 29 U.S.C. §1144(b)(2), was nevertheless preempted because it conflicted with a written plan term. 526

U.S. at 375. The Court rejected that argument, reasoning that allowing insurers to "displace any state regulation simply by inserting a contrary term in plan documents" would "virtually read the saving clause out of ERISA." Id. at 376.

UNUM did not address a case like this one, where a state law conflicts with the terms of a *self-funded ERISA plan* and thus cannot be saved from preemption by the insurance-savings clause. *See infra* pp. 55-56. The question in this case is whether Vermont's reporting requirements "relate to" an ERISA plan in the first instance. In answering that question, there should be no doubt that a state law that alters the commitments a plan makes to its members in plan documents "relates" to that plan and is thus subject to preemption under 29 U.S.C. §1144(a).

Indeed, the Court's decision in *UNUM* supports Liberty Mutual's position. In *UNUM*, there was apparently no dispute that the state law at issue "related to" an employee benefit plan and thus fell within the scope of ERISA's preemption clause. 526 U.S. at 367. Absent the insurance-savings clause, the law at issue in *UNUM* would have been preempted. Here, Vermont's reporting requirements—like the law at issue in *UNUM*—relate to an employee benefit plan because those requirements conflict with the terms of the Plan. Unlike the law at issue in *UNUM*, however, the insurance-savings clause does not save Vermont's reporting requirements as applied to Liberty Mutual's plan, because the plan is self-funded. *See infra* pp. 55-56.

3. There is no merit to the United States' argument that there is "no evident conflict between the terms of respondent's plan and the Vermont reporting requirements." U.S. Br. 34. The United States ap-

pears to suggest that a conflict could exist only if Liberty Mutual had included in its plan documents a promise to its Members to "refuse to report claims information to state authorities in compliance with state law." *Id.* But the relevant question is whether the Vermont law's requirements are inconsistent with Liberty Mutual's obligations to its members under the Plan, not whether Liberty Mutual has made an express promise to its members not to comply with state law.[28] As already discussed, here the Vermont law is inconsistent with Liberty Mutual's obligations to its members because it has the effect of reassigning the ultimate obligation to keep members' health information confidential from Liberty Mutual and its TPA to the State.

III. PETITIONER'S REMAINING ARGUMENTS LACK MERIT

A. Other Federal Statutes Do Not Support Petitioner's Position

Petitioner and the United States point to other federal enactments that, they contend, support the conclusion that ERISA does not preempt Vermont's reporting requirements. Pet. Br. 45-50; U.S. Br. 19-22. Those enactments yield no reason to doubt that Congress intended to preempt state laws requiring ERISA plans to report on a core activity of the plan: providing benefits by paying claims.

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[28] Under the United States' view, for example, there would be no conflict—and thus no preemption—in a case where plan documents and state law prescribed different rules for determining beneficiary status unless the plan also included language expressly stating that it would refuse to determine beneficiary status in compliance with state law.

1. Petitioner contends that the National Health Planning and Resources Development Act of 1974 (NHPRDA) shows that "Congress ... could not have intended ERISA to preempt state data-collection efforts" and instead "contemplated both a substantial state role in developing health care policy and reliance on comprehensive data about state health care systems." Pet. Br. 46-47. Petitioner's reliance on that repealed statute is misplaced. The NHPRDA was relevant to this Court's decision in *Travelers* that ERISA does not preempt state health care rate regulation because the NHPRDA envisioned a system of state regulation covering the same ground as the New York law at issue. The Court observed that the "the statute's provision for comprehensive aid to state health care rate regulation is simply incompatible with pre-emption of the same by ERISA." 514 U.S. at 667. Preempting the New York law "would have rendered the entire NHPRDA utterly nugatory, since it would have left States without the authority to do just what Congress was expressly trying to induce them to do by enacting the NHPRDA." *Id.*

The NHPRDA has no relevance to the kind of state regulation at issue here. That statute did not direct the States to collect claims information from ERISA plans or even express a general intent that States should be able to do so. Indeed, the first state statute imposing claims reporting requirements on self-insured plans was not enacted until 2003, decades after Congress enacted the NHPRDA. There is no conflict between a holding that ERISA preempts state reporting requirements and the scope of state regulation envisioned by the NHPRDA.

2. Petitioner and the United States also identify various provisions of the Patient Protection and Af-

fordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), that supposedly "rely on or encourage state data-collection efforts similar to Vermont's." U.S. Br. 20; *see also* Pet. Br. 48-50. Congress's enactment of the ACA, however, says nothing about what Congress meant when it enacted ERISA's preemption provision 36 years earlier. "[T]he views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one." *Marvin M. Brandt Revocable Trust* v. *United States*, 134 S. Ct. 1257, 1268 (2014).

In any event, the ACA provisions are fully consistent with preemption of Vermont's reporting requirements as applied to ERISA plans. The ACA provision authorizing the Secretary of Health and Human Services (HHS) to provide Medicare claims data for use in state claims databases, 42 U.S.C. §1395kk(e), illustrates merely that the federal government can decide what use it will make of the claims data in its own possession. That Congress decided, voluntarily, to give the federal government's own claims data to the States provides no reason to believe that Congress thought *each State* could *mandate* the same and other information from ERISA plans.

Nor would preemption adversely affect the Center for Medicare and Medicaid Innovation (CMMI). The ACA established CMMI for the purpose of "test[ing] innovative payment and service delivery models to reduce program expenditures." 42 U.S.C. §1315a(a)(1). The statute provides a non-exhaustive list of 24 models that CMMI "may" test, including "[a]llowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State." *Id.* §1315a(b)(2)(B)(xi). The United States argues that preemption of APCD statutes "would impede CMMI's statutory mission" by depriving it of "access to com-

prehensive state-level databases" that are "important for evaluating models." U.S. Br. 20-21. But nothing in the ACA *requires* the existence of state APCDs that obtain information from ERISA plans and, at any rate, nothing prevents the federal government from requiring plans to report claims data directly to a federal agency, pursuant to a uniform federal standard. Separate state reporting requirements are not necessary for CMMI to discharge its statutory duties.[29]

Indeed, the ACA imposes new *federal* reporting requirements on ERISA plans, including ones mandating disclosure of "[c]laims payment policies and practices," "[d]ata on enrollment," and "[d]ata on the number of claims that are denied." 42 U.S.C. §18031(e)(3)(A); *see id.* §300gg-15a (making requirements applicable to "group health plans"); *see also* 29 U.S.C. §1191b(a)(1) (defining "group health plan" to include ERISA plan). The ACA then directs the Secretary of Labor to "update and harmonize" existing ERISA disclosure rules with the new standards the Secretary of HHS establishes to implement the ACA's new reporting requirements. 42 U.S.C. §18031(e)(3)(D). And the ACA amends ERISA to make clear that the ACA's new fed-

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[29] Petitioner also asserts that HHS has awarded grants to States to encourage APCDs. Pet. Br. 49-50. But those grants have been provided to States with and without APCDs, indicating that they do not depend on APCDs. *See* CMS, Rate Review Grants, https://www.cms.gov/CCIIO/Resources/Rate-Review-Grants (last visited Oct. 13, 2015). And in any event, a federal agency's decision to award grants sheds no light on congressional intent as to ERISA's preemptive scope.

eral requirements "shall apply" to ERISA plans. 29 U.S.C. §1185d(a)(1).[30]

The fact that Congress enacted those changes but left ERISA's preemption clause untouched is telling. It illustrates Congress's continued recognition that reporting requirements would be imposed on ERISA plans only by the federal government and would need to be harmonized under a *federal* standard. Congress saw no reason to disturb the settled understanding that reporting by employee benefit plans falls exclusively within the federal domain.[31]

3. To the extent congressional action subsequent to ERISA is relevant, it points in favor of preemption. In 1974, Hawaii passed its Prepaid Health Care Act, which "required workers in the State to be covered by a comprehensive prepaid health care plan" and imposed "certain reporting requirements which differ[ed] from those of ERISA." *Standard Oil Co. of Cal.* v. *Agsalud*, 442 F. Supp. 695, 696 (N.D. Cal. 1977), *aff'd*, 633 F.2d 760 (9th Cir. 1980), *aff'd*, 454 U.S. 801 (1981). Hawaii's

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[30] The ACA makes other changes to ERISA as well, including specifically to ERISA disclosure and reporting requirements. *See* ACA §6606, 124 Stat. 781, *amending* 29 U.S.C. §1021(g).

[31] The ACA does not *expand* ERISA preemption, as the United States suggests Liberty Mutual might argue. U.S. Br. 21. Rather, the ACA *confirms* that ERISA makes reporting requirements exclusively federal. Particularly unpersuasive is the government's reliance on 29 U.S.C. §1191(a)(2), as that provision makes clear that there is "*[c]ontinued preemption* with respect to group health plans" (emphasis added). Moreover, the government's recognition that ACA's reporting requirements "focus on *plans* as such," U.S. Br. 22, confirms that reporting requirements implicate core ERISA plan functions. Although Vermont's law is broader than only ERISA plans, it is preempted as applied to ERISA plans.

implementing regulation required all "health care contractors"—which could include self-insurers—to report annually to the State information much like the information Vermont seeks for use in its claims database, including the "[n]umber of claims filed by covered employees," the "[n]umber of claims paid to covered employees," and the "[a]mount of claims paid to covered employees." JA188, JA196-197. The lower courts held that ERISA preempted the Hawaii law, including its reporting requirements, and this Court summarily affirmed. *Agsalud* v. *Standard Oil Co. of Cal.*, 454 U.S. 801 (1981).

Congress subsequently amended ERISA to exempt portions of the Hawaii statute from preemption. But "[t]he amendment did not exempt from preemption those portions of the law dealing with reporting, disclosure, and fiduciary requirements." *Fort Halifax*, 482 U.S. at 13 n.7 (citing 29 U.S.C. §1144(b)(5)). Congress's decision to leave Hawaii's reporting requirements preempted indicates its agreement that such requirements lie within the scope of ERISA's preemption provision. There is no reason to believe that Congress would think differently about Vermont's similar reporting requirements.

B. Vermont's Reporting Requirements Are Not Shielded From Preemption As a Generally Applicable State Health Care Regulation

1. Relying heavily on this Court's decisions in *Travelers* and *De Buono*, petitioner and the United States argue that Vermont's reporting regime is not preempted because it is merely "an exercise of traditional and longstanding state authority to regulate health care." Pet. Br. 29; *see* U.S. Br. 23-24. Further, petitioner argues, preemption here would "cast doubt

on common state laws that protect health and safety." Pet. Br. 44. That alarmist argument is without merit.

Vermont's reporting regime has an entirely different focus than the laws at issue in *Travelers* and *De Buono*. Vermont demands records and reports from those who pay for health care benefits. That is what employee welfare benefit plans, by their very nature, do: They pay for employee benefits. Although the Vermont regime is not limited to ERISA plans, it covers them because they engage in the very activity that makes them ERISA plans.

The state laws upheld in *Travelers* and *De Buono* operated completely differently. Unlike Vermont's Database Statute, they were not directed at the payment of benefits. Rather, those laws were directed at hospitals, not insurers and other health care payers, and this Court explained that laws regulating hospitals should be understood as general health care regulation, not regulation of welfare plans covered by ERISA. Indeed, the law at issue in *Travelers* did not even apply to ERISA plans; the law required hospitals to collect surcharges on hospital bills paid by commercial insurers but not on hospital bills paid by Blue Cross and Blue Shield Plans. 514 U.S. at 649. Although the law in *De Buono*, which imposed a gross receipts tax on the income of hospitals, did apply to some ERISA plans, the law did not apply to self-insured plans because the plans were engaging in their core ERISA activity of paying benefits. Rather, the law applied to the plans at issue because they had chosen to provide health benefits by operating their own hospitals and thus were subject to the state law. 520 U.S. at 809. That the hospitals were operated by ERISA plans was a happenstance; as the Court explained, "[m]ost hospitals are not owned or operated by ERISA funds." *Id.* at 816.

Here, by contrast, the application of Vermont's reporting regime to ERISA plans is not a happenstance. The scope of the Database Statute and the implementing Regulation are expressly defined to include administrators of self-insured employee benefit plans within the reach of the reporting regime. *See supra* pp. 5-7. Self-insured plans are included not because they have entered another line of business subject to state regulation (like hospitals) but because they are doing exactly what they were established to do.

That point explains why petitioner's other examples of state laws that would supposedly fall are flawed. Pet. Br. 44. Those laws would apply to ERISA plans not because they provide benefits under a plan, but because they choose to engage in other activities that are subject to state regulation. For example, the obligation that a plan-run hospital "report infections, mortality, or other public health data" does not arise because a self-insured plan is engaged in its core function of providing medical benefits, but because the plan chooses to operate a hospital subject to state laws directed at hospitals generally. *Cf. De Buono*, 520 U.S. at 809. Similarly, state requirements that day care centers report on attendance, safety measures, or teacher qualifications can be applied to plan-run day care centers because such reporting obligations are not directed at the core plan activity of providing benefits.

Contrary to petitioner's suggestion (Pet. Br. 40), the court of appeals below did not hold—and Liberty Mutual does not contend—"that requiring a plan to provide information for any purpose, in any context, intrudes on a core ERISA function." Rather, the court of appeals properly noted that ERISA's preemption provision allows for reporting laws that "create no impediment to an employer's adoption of a uniform bene-

fit administration scheme" and have "too tenuous, remote or peripheral an effect on employee benefit plans." Pet. App. 24. The court made clear, however, that Vermont's reporting requirements are different from such laws because they "implicate an ERISA core administrative concern" by requiring ERISA plans to report "information about the essential functioning of employee health plans." *Id.* 29 n.13. There is nothing "tenuous, remote or peripheral" about a state administrative obligation that arises as a result of ERISA plans providing benefits to their participants.

2. Certain amici suggest that state APCD laws like Vermont's could be understood as an aspect of the State's regulation of insurance and potentially be saved from preemption by ERISA's insurance-savings clause, 29 U.S.C. §1144(b)(2)(A). *See* NGA Br. 9 n.12; AMA Br. 27 n.11. This Court ordinarily will not consider arguments raised only by an amicus. *Robertson* v. *Seattle Audubon Soc'y*, 503 U.S. 429, 441 (1992). In any event, the argument is without merit.

Even if the Database Statute fell within ERISA's insurance-savings clause, it nonetheless could not be applied to a self-insured plan like the Liberty Mutual Plan because of ERISA's "deemer" clause, 29 U.S.C. §1144(b)(2)(B). That clause prevents States from extending even their "generally applicable" insurance regulations to self-insured employee benefit plans. *See FMC*, 498 U.S. at 61; *Metropolitan Life*, 471 U.S. at 748. The deemer clause also prevents States from indirectly regulating self-insured plans through their TPAs. *See America's Health Ins. Plans* v. *Hudgens*, 742 F.3d 1319, 1333-13334 n.18 (11th Cir. 2014); *Prudential Ins. Co. of Am.* v. *National Park Med. Ctr., Inc.*, 413 F.3d 897, 912-913 (8th Cir. 2005). The deemer clause thus reinforces

that Vermont's reporting regime, as applied to the Liberty Mutual Plan, is preempted by ERISA.

C. Liberty Mutual's Use Of A Third-Party Administrator Does Not Exempt Vermont's Reporting Mandate From ERISA

Petitioner and the United States also argue that Liberty Mutual cannot show that ERISA preempts Vermont's reporting requirements because Liberty Mutual uses a third party to administer its plan. Pet. Br. 53-54; U.S. Br. 28-29. As the Second Circuit and others have explained, however, "'the objective of uniformity in plan administration' is not 'for some reason inapplicable simply because a plan has contracted with a third party to provide administrative services.'" Pet. App. 23 n.10 (quoting *Pharmaceutical Care Mgmt. Ass'n* v. *District of Columbia*, 613 F.3d 179, 182 (D.C. Cir. 2010)); *see also America's Health Ins. Plans*, 742 F.3d at 1331-1332; *NGS Am., Inc.* v. *Barnes*, 998 F.2d 296, 300 (5th Cir. 1993). ERISA preempts state laws that disrupt uniform administration by "plan administrators," *Egelhoff*, 532 U.S. at 150, whether those administrators are employed directly by the plan or by a third party that charges the plan for their services.

Liberty Mutual pays its TPA for the costs of administering its plan. Although the TPA may encounter the burden of reporting Liberty Mutual's data to Vermont (and other States) in the first instance, Liberty Mutual will ultimately compensate its TPA for those additional costs of administration. In an efficient market, after all, third-party administrators fully pass on their costs to self-insured plans. *See East Tex. Baptist Univ.* v. *Burwell*, 793 F.3d 449, 460 (5th Cir. 2015).

There is no statutory, doctrinal, or policy basis for exempting Vermont's reporting requirement from

ERISA preemption simply because Liberty Mutual's TPA actually undertakes the reporting obligation. To hold otherwise would only discourage ERISA plans from using TPAs at a time when they have become increasingly important as plan administration has grown more complex. *See* Advisory Council on Employee Welfare and Pension Benefit Plans, Outsourcing Employee Benefit Plan Services: Report to the U.S. Secretary of Labor 4-6 (Nov. 2014), *available at* http://www.dol.gov/ebsa/pdf/2014ACreport3.pdf. And Liberty Mutual's choice whether to have its benefits administered in-house or by a TPA is itself a matter of plan administration that ERISA leaves to the plan's judgment; under ERISA's preemption clause, that choice should not be affected by the operation of state law. *See Pharmaceutical Care Mgmt. Ass'n*, 613 F.3d at 188.

Moreover, petitioner's argument elides that both self-insured plans and their TPAs fall within the Vermont regulation's definition of a "Health Insurer" that must report data. *See* Regulation H-2008-01 §3(X).[32] The only reason Liberty Mutual is itself not a mandatory reporter is that it currently has fewer than 200 members in Vermont, but that may change. Even now, the burden of complying with Vermont's regulation falls on Liberty Mutual; the TPA has Liberty Mutual's data and is required to report that data solely because of the services it provides Liberty Mutual, and the Plan will ultimately bear the cost of reporting.[33]

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[32] Petitioner now suggests that self-insured plans might not fall within the definition, Pet. Br. 53 n.33, but it did not dispute below that they did, *see* Pet. App. 54.

[33] Certain amici suggest that APCD laws implicate self-insured plans' claims data only because those laws apply to third-party administrators (along with traditional insurers), but not self-

D. This Court's Mode Of Preemption Analysis Does Not Change The Relevant Inquiry

Finally, petitioner and the United States discuss whether ERISA preemption is best analyzed as a form of "field preemption." *See* Pet. Br. 30 n.16; U.S. Br. 30-32. Several Justices have suggested that ERISA preemption cases are best analyzed under the field-preemption rubric. *E.g.*, *Dillingham*, 519 U.S. at 336 (Scalia, J., concurring); *see also Egelhoff*, 532 U.S. at 153 (Breyer, J., dissenting). It is unnecessary to resolve that debate in this case. The result in this case would not be different if the express-preemption or the field-preemption approach were used (and petitioner does not argue otherwise). The field that is preempted by ERISA, employee benefit plans, encompasses reporting and disclosure about the core activities of those plans, including paying benefits under a plan. ERISA established uniform reporting requirements, not minimum ones. Because Vermont's mandate purports to supplement those requirements, it is preempted.[34]

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insured plans themselves. *See* N.Y. Br. 31. Whatever the merits of that point regarding other state laws, it is clearly inapplicable to Vermont, which has extended its regime to self-insured plans themselves. *See supra* pp. 5-7. In any event, that claims data may be in the hands of a TPA is irrelevant; the information belongs to the plan, and the plan will ultimately bear the burden of ensuring that it is reported to the State.

[34] What would be clearly wrong would be to reduce ERISA preemption to a question of conflict preemption. *Cf.* U.S. Br. 31-35. ERISA contains a broad express preemption provision, and this Court's cases clearly recognize that the scope of preemption under that provision is far broader than the application of this Court's conflict-preemption jurisprudence. *See Metropolitan Life*, 471 U.S. at 737.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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APPENDIX

U.S. Const. art. VI, cl. 2

This Constitution, and the Laws of the United States which shall be made in pursuance thereof; and all treaties made, or which shall be made, under the authority of the United States, shall be the supreme law of the land; and the judges in every state shall be bound thereby, anything in the constitution or laws of any state to the contrary notwithstanding.

UNITED STATES CODE

TITLE 29. LABOR
CHAPTER 18. EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM

29 U.S.C. §1002. Definitions

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

* * *

(3) The term "employee benefit plan" or "plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.

* * *

29 U.S.C. §1023. Annual reports

(a) Publication and filing

(1)(A) An annual report shall be published with respect to every employee benefit plan to which this part applies. Such report shall be filed with the Secretary in accordance with section 1024(a) of this title, and shall be made available and furnished to participants in accordance with section 1024(b) of this title.

* * *

(e) Statement from insurance company, insurance service, or other similar organizations which sell or guarantee plan benefits

If some or all of the benefits under the plan are purchased from and guaranteed by an insurance company, insurance service, or other similar organization, a report under this section shall include a statement from such insurance company, service, or other similar organization covering the plan year and enumerating—

(1) the premium rate or subscription charge and the total premium or subscription charges paid to each such carrier, insurance service, or other similar organization and the approximate number of persons covered by each class of such benefits; and

(2) the total amount of premiums received, the approximate number of persons covered by each class of benefits, and the total claims paid by such company, service, or other organization; dividends or retroactive rate adjustments, commissions, and administrative service or other fees or other specific acquisition costs paid by such company, service, or other organization; any amounts held to provide benefits after retirement; the remainder of such

premiums; and the names and addresses of the brokers, agents, or other persons to whom commissions or fees were paid, the amount paid to each, and for what purpose. If any such company, service, or other organization does not maintain separate experience records covering the specific groups it serves, the report shall include in lieu of the information required by the foregoing provisions of this paragraph (A) a statement as to the basis of its premium rate or subscription charge, the total amount of premiums or subscription charges received from the plan, and a copy of the financial report of the company, service, or other organization and (B) if such company, service, or organization incurs specific costs in connection with the acquisition or retention of any particular plan or plans, a detailed statement of such costs.

* * *

29 U.S.C. §1024. Filing with Secretary and furnishing information to participants and certain employers

(a) Filing of annual report with Secretary

(1) The administrator of any employee benefit plan subject to this part shall file with the Secretary the annual report for a plan year within 210 days after the close of such year (or within such time as may be required by regulations promulgated by the Secretary in order to reduce duplicative filing). The Secretary shall make copies of such annual reports available for inspection in the public document room of the Department of Labor.

(2)(A) With respect to annual reports required to be filed with the Secretary under this part, he may by

regulation prescribe simplified annual reports for any pension plan which covers less than 100 participants.

(B) Nothing contained in this paragraph shall preclude the Secretary from requiring any information or data from any such plan to which this part applies where he finds such data or information is necessary to carry out the purposes of this subchapter nor shall the Secretary be precluded from revoking provisions for simplified reports for any such plan if he finds it necessary to do so in order to carry out the objectives of this subchapter.

(3) The Secretary may by regulation exempt any welfare benefit plan from all or part of the reporting and disclosure requirements of this subchapter, or may provide for simplified reporting and disclosure if he finds that such requirements are inappropriate as applied to welfare benefit plans.

* * *

29 U.S.C. §1104. Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter.

(2) In the case of an eligible individual account plan (as defined in section 1107(d)(3) of this title), the diversification requirement of paragraph (1)(C) and the prudence requirement (only to the extent that it requires diversification) of paragraph (1)(B) is not violated by acquisition or holding of qualifying employer real property or qualifying employer securities (as defined in section 1107(d)(4) and (5) of this title).

* * *

29 U.S.C. §1143. Research, studies, and reports

(a) Authorization to undertake research and surveys

(1) The Secretary is authorized to undertake research and surveys and in connection therewith to collect, compile, analyze and publish data, information, and statistics relating to employee benefit plans, including retirement, deferred compensation, and welfare plans, and types of plans not subject to this chapter.

(2) The Secretary is authorized and directed to undertake research studies relating to pension plans, including but not limited to (A) the effects of this subchapter upon the provisions and costs of pension plans, (B) the role of private pensions in meeting the economic security needs of the Nation, and (C) the operation of private pension plans including types and levels of benefits, degree of reciprocity or portability, and financial and actuarial characteristics and practices, and methods of encouraging the growth of the private pension system.

(3) The Secretary may, as he deems appropriate or necessary, undertake other studies relating to employee benefit plans, the matters regulated by this subchapter, and the enforcement procedures provided for under this subchapter.

(4) The research, surveys, studies, and publications referred to in this subsection may be conducted directly, or indirectly through grant or contract arrangements.

* * *

29 U.S.C. §1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§393–1 through 393–51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section—

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

(6)(A) Notwithstanding any other provision of this section—

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides—

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insur-

ance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) of this section shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title), qualified medical child support orders (within the meaning of section 1169(a)(2)(A) of this title), and the provisions of law referred to in section 1169(a)(2)(B)(ii) of this title to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action—

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 1191 of this title.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Co-

lumbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

(e) Automatic contribution arrangements

(1) Notwithstanding any other provision of this section, this subchapter shall supersede any law of a State which would directly or indirectly prohibit or restrict the inclusion in any plan of an automatic contribution arrangement. The Secretary may prescribe regulations which would establish minimum standards that such an arrangement would be required to satisfy in order for this subsection to apply in the case of such arrangement.

(2) For purposes of this subsection, the term "automatic contribution arrangement" means an arrangement—

(A) under which a participant may elect to have the plan sponsor make payments as contributions under the plan on behalf of the participant, or to the participant directly in cash,

(B) under which a participant is treated as having elected to have the plan sponsor make such contributions in an amount equal to a uniform percentage of compensation provided under the plan until the participant specifically elects not to have such contributions made (or specifically elects to have such contributions made at a different percentage), and

(C) under which such contributions are invested in accordance with regulations prescribed by the Secretary under section 1104(c)(5) of this title.

(3)(A) The plan administrator of an automatic contribution arrangement shall, within a reasonable period before such plan year, provide to each participant to whom the arrangement applies for such plan year notice of the participant's rights and obligations under the arrangement which—

(i) is sufficiently accurate and comprehensive to apprise the participant of such rights and obligations, and

(ii) is written in a manner calculated to be understood by the average participant to whom the arrangement applies.

(B) A notice shall not be treated as meeting the requirements of subparagraph (A) with respect to a participant unless—

(i) the notice includes an explanation of the participant's right under the arrangement not to have elective contributions made on the participant's behalf (or to elect to have such contributions made at a different percentage),

(ii) the participant has a reasonable period of time, after receipt of the notice described in clause

(i) and before the first elective contribution is made, to make such election, and

(iii) the notice explains how contributions made under the arrangement will be invested in the absence of any investment election by the participant.

29 U.S.C. §1204. Coordination between the Department of the Treasury and the Department of Labor

(a) Whenever in this chapter or in any provision of law amended by this chapter the Secretary of the Treasury and the Secretary of Labor are required to carry out provisions relating to the same subject matter (as determined by them) they shall consult with each other and shall develop rules, regulations, practices, and forms which, to the extent appropriate for the efficient administration of such provisions, are designed to reduce duplication of effort, duplication of reporting, conflicting or overlapping requirements, and the burden of compliance with such provisions by plan administrators, employers, and participants and beneficiaries.

* * *

VERMONT STATUTES ANNOTATED

TITLE EIGHTEEN. HEALTH
PART 9. UNIFIED HEALTH CARE SYSTEM
CHAPTER 221. HEALTH CARE ADMINISTRATION
SUBCHAPTER 1. QUALITY, RESOURCE ALLOCATION, AND COST CONTAINMENT

18 V.S.A. §9402. Definitions

* * *

(8) "Health insurer" means any health insurance company, nonprofit hospital and medical service corporation, managed care organizations, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities.

* * *

18 V.S.A. §9410. Health care database

(a)(1) The Board shall establish and maintain a unified health care database to enable the Board to carry out its duties under this chapter, chapter 220 of this title, and Title 8, including:

(A) determining the capacity and distribution of existing resources;

(B) identifying health care needs and informing health care policy;

(C) evaluating the effectiveness of intervention programs on improving patient outcomes;

(D) comparing costs between various treatment settings and approaches;

(E) providing information to consumers and purchasers of health care; and

(F) improving the quality and affordability of patient health care and health care coverage.

(2) [Repealed.]

(b) The database shall contain unique patient and provider identifiers and a uniform coding system, and shall reflect all health care utilization, costs, and resources in this State, and health care utilization and costs for services provided to Vermont residents in another state.

(c) Health insurers, health care providers, health care facilities, and governmental agencies shall file reports, data, schedules, statistics, or other information determined by the Board to be necessary to carry out the purposes of this section. Such information may include:

(1) health insurance claims and enrollment information used by health insurers;

(2) information relating to hospitals filed under subchapter 7 of this chapter (hospital budget reviews); and

(3) any other information relating to health care costs, prices, quality, utilization, or resources required by the Board to be filed.

(d) The Board may by rule establish the types of information to be filed under this section, and the time and place and the manner in which such information shall be filed.

(e) Records or information protected by the provisions of the physician-patient privilege under 12 V.S.A. §1612(a), or otherwise required by law to be held confidential, shall be filed in a manner that does not disclose the identity of the protected person.

(f) The Board shall adopt a confidentiality code to ensure that information obtained under this section is handled in an ethical manner.

(g) Any person who knowingly fails to comply with the requirements of this section or rules adopted pursuant to this section shall be subject to an administrative penalty of not more than $ 1,000.00 per violation. The Board may impose an administrative penalty of not more than $ 10,000.00 each for those violations the Board finds were willful. In addition, any person who knowingly fails to comply with the confidentiality requirements of this section or confidentiality rules adopted pursuant to this section and uses, sells, or transfers the data or information for commercial advantage, pecuniary gain, personal gain, or malicious harm shall be subject to an administrative penalty of not more than $ 50,000.00 per violation. The powers vested in the Board by this subsection shall be in addition to any other powers to enforce any penalties, fines, or forfeitures authorized by law.

(h)(1) All health insurers shall electronically provide to the Board in accordance with standards and procedures adopted by the Board by rule:

(A) their health insurance claims data, provided that the Board may exempt from all or a portion of the filing requirements of this subsection data reflecting utilization and costs for services provided in this State to residents of other states;

(B) cross-matched claims data on requested members, subscribers, or policyholders; and

(C) member, subscriber, or policyholder information necessary to determine third party liability for benefits provided.

(2) The collection, storage, and release of health care data and statistical information that is subject to the federal requirements of the Health Insurance Portability and Accountability Act (HIPAA) shall be governed exclusively by the regulations adopted thereunder in 45 C.F.R. Parts 160 and 164.

(A) All health insurers that collect the Health Employer Data and Information Set (HEDIS) shall annually submit the HEDIS information to the Board in a form and in a manner prescribed by the Board.

(B) All health insurers shall accept electronic claims submitted in Centers for Medicare and Medicaid Services format for UB-92 or HCFA-1500 records, or as amended by the Centers for Medicare and Medicaid Services.

(3)(A) The Board shall collaborate with the Agency of Human Services and participants in the Agency's initiatives in the development of a comprehensive health care information system. The collaboration is intended to address the formulation of a description of the data sets that will be included in the comprehensive health care information system, the criteria and procedures for the development of limited-use data sets, the criteria and procedures to ensure that HIPAA compliant limited-use data sets are accessible, and a proposed time frame for the creation of a comprehensive health care information system.

(B) To the extent allowed by HIPAA, the data shall be available as a resource for insurers, employers, providers, purchasers of health care, and State agencies to continuously review health care utilization, expenditures, and performance in Vermont. In presenting data for public access, comparative considerations shall be made regarding geography, demographics, general economic factors, and institutional size.

(C) Consistent with the dictates of HIPAA, and subject to such terms and conditions as the Board may prescribe by rule, the Vermont Program for Quality in Health Care shall have access to the unified health care database for use in improving the quality of health care services in Vermont. In using the database, the Vermont Program for Quality in Health Care shall agree to abide by the rules and procedures established by the Board for access to the data. The Board's rules may limit access to the database to limited-use sets of data as necessary to carry out the purposes of this section.

(D) Notwithstanding HIPAA or any other provision of law, the comprehensive health care information system shall not publicly disclose any data that contains direct personal identifiers. For the purposes of this section, "direct personal identifiers" include information relating to an individual that contains primary or obvious identifiers, such as the individual's name, street address, e-mail address, telephone number, and Social Security number.

(i) On or before January 15, 2018 and every three years thereafter, the Commissioner of Health shall submit a recommendation to the General Assembly for conducting a survey of the health insurance status of Vermont residents. The provisions of 2 V.S.A.

§20(d)(expiration of required reports) shall not apply to the report to be made under this subsection.

(j)(1) As used in this section, and without limiting the meaning of subdivision 9402(8) of this title, the term "health insurer" includes:

(A) any entity defined in subdivision 9402(8) of this title;

(B) any third party administrator, any pharmacy benefit manager, any entity conducting administrative services for business, and any other similar entity with claims data, eligibility data, provider files, and other information relating to health care provided to a Vermont resident, and health care provided by Vermont health care providers and facilities required to be filed by a health insurer under this section;

(C) any health benefit plan offered or administered by or on behalf of the State of Vermont or an agency or instrumentality of the State; and

(D) any health benefit plan offered or administered by or on behalf of the federal government with the agreement of the federal government.

(2) The Board may adopt rules to carry out the provisions of this subsection, including criteria for the required filing of such claims data, eligibility data, provider files, and other information as the Board determines to be necessary to carry out the purposes of this section and this chapter.

VERMONT DEPARTMENT OF BANKING, INSURANCE, SECURITIES AND HEALTH CARE ADMINISTRATION

REGULATION H-2008-01

Vermont Healthcare Claims Uniform Reporting and Evaluation System ("VHCURES")

Section 1: Purpose

The purpose of this rule is to set forth the requirements for the submission of health care claims data, member eligibility data, and other information relating to health care provided to Vermont residents or by Vermont health care providers and facilities by health insurers, managed care organizations, third party administrators, pharmacy benefit managers and others to the Department of Banking, Insurance, Securities and Health Care Administration and conditions for the use and dissemination of such claims data, all as required by and consistent with the purposes of 18 V.S.A. §9410.

Section 2: Authority

This rule is issued pursuant to the authority vested in the Commissioner of the Department of Banking, Insurance, Securities and Health Care Administration by 18 V.S.A. §9410, as well as 8 V.S.A. §15 and other applicable portions of Chapter 221 of Title 18.

Section 3: Definitions

As used in this Rule

A. "BISHCA" or "Department" means the Vermont Department of Banking, Insurance, Securities and Health Care Administration.

B. "Capitated services" means services rendered by a provider through a contract in which payment are based upon a fixed dollar amount for each member on a monthly basis.

C. "Cell size" means the count of persons that share a set of characteristics contained in a statistical table.

D. "Charge" means the actual dollar amount charged on the claim.

E. "Co-insurance" means the percentage a member pays toward the cost of a covered service.

F. "Commissioner" means the commissioner of the Department of Banking, Insurance, Securities and Health Care Administration or his or her designee.

G. "Co-payment" means the fixed dollar amount a member pays to a health care provider at the time a covered service is provided or the full cost of a service when that is less than the fixed dollar amount.

H. "Current Procedural Terminology (CPT)" means a medical code set of physician and other services, maintained and copyrighted by the American Medical Association (AMA), and adopted by the U.S. Secretary of Health and Human Services as the standard for reporting physician and other services on standard transactions.

I. "Data set" means a collection of individual data records, whether in electronic or manual files.

J. "Deductible" means the total dollar amount a member pays towards the cost of covered services over an established period of time before the contracted third-party payer makes any payments.

K. "De-identified health information" means information that does not identify an individual patient, member or enrollee and with respect to which no reasonable basis exists to believe that the information can be used to identify an individual patient, member or enrollee. De-identification means that health information is not individually identifiable and requires the removal of Direct Personal Identifiers associated with patients, members or enrollees.

L. "Direct personal identifiers" is information relating to an individual patient, member or enrollee that contains primary or obvious identifiers, including:

(1) Names;

(2) Business names when that name would serve to identify a person;

(3) Postal address information other than town or city, state, and 5-digit zip code;

(4) Specific latitude and longitude or other geographic information that would be used to derive postal address;

(5) Telephone and fax numbers;

(6) Electronic mail addresses;

(7) Social security numbers;

(8) Vehicle Identifiers and serial numbers, including license plate numbers;

(9) Medical record numbers;

(10) Health plan beneficiary numbers;

(11) Certificate and license numbers;

(12) Internet protocol (IP) addresses and uniform resource locators (URL) that identify a business that would serve to identify a person;

(13) Biometric identifiers, including finger and voice prints; and

(14) Personal photographic images.

M. "Disclosure" means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

N. "Encrypted identifier" is a code or other means of record identification to allow patients, members or enrollees to be tracked across the data set without revealing their identity. Encrypted identifiers are not direct identifiers.

O. "Encryption" means a method by which the true value of data has been disguised in order to prevent the identification of persons or groups, and which does not provide the means for recovering the true value of the data.

P. "Health benefit plan" means a policy, contract, certificate or agreement entered into, or offered by a health insurer to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Q. "Healthcare claims data" means information consisting of or derived directly from member eligibility files, medical claims files, pharmacy claims files and other related data pursuant to the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) in effect at the time of the data submission. "Healthcare claims data" does not include analysis, reports, or studies containing

information from health care claims data sets if those analyses, reports, or studies have already been released in response to another request for information or as part of a general distribution of public information by BISHCA.

R. "Healthcare premium" means the dollar amount charged for any policies offered by health insurers which partially or fully cover the cost of health care services.

S. "Healthcare Common Procedure Coding System (HCPCS)" means a medical code set that identifies health care procedures, equipment, and supplies for claim submission purposes. These are often known as "local codes".

T. "Health care" means care, services, or supplies related to the health of an individual. It includes but is not limited to (1) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and (2) sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription [45 CFR §160.103].

U. "Health care facility" shall be defined as per 18 V.S.A §9432, as amended from time to time.

V. "Health care provider" means a person, partnership, corporation, facility or institution, licensed or certified or authorized by law to provide professional health care service in this state to an individual during that individual's medical care, treatment or confinement, as per 18 V.S.A. §9432.

W. "Health information" means any information, whether oral or recorded in any form or medium, that 1) is created or received by a health-care provider, health plan, public health authority, employer, life insurer, school or university, or health-care clearinghouse; and 2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual shall be as defined in 45 CFR §160.103.

X. "Health insurer" means those entities defined in 18 V.S.A. §§9402 and 9410(j)(1), and includes any health insurance company, nonprofit hospital and medical service corporation, managed care organization, third party administrator, pharmacy benefit manager, and any entity conducting administrative services for business or possessing claims data, eligibility data, provider files, and other information relating to health care provided to Vermont residents or by Vermont health care providers and facilities. The term may also include, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities.

Y. "HIPAA" means the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

Z. "Indirect personal identifiers" means information relating to an individual patient, member or enrollee that a person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods could apply to

render such information individually identifiable by using such information alone or in combination with other reasonably available information.

Aa. "International Classification of Diseases" or "ICD" shall mean that medical code set maintained by the World Health Organization.

Ab. "Mandated Reporter" means a health insurer as defined herein and at 18 V.S.A. §9410(j)(1) with two hundred (200) or more enrolled or covered members in each month during a calendar year, including both Vermont residents and any non-residents receiving covered services provided by Vermont health care providers and facilities.

Ac. "Medical claims file" means a data file composed of service level remittance information for all non-denied adjudicated claims for each billed service including, but not limited to member demographics, provider information, charge/payment information, and clinical diagnosis and procedure codes, and shall include all claims related to behavioral or mental health.

Ad. "Member" means the insured subscriber and any spouse and/or dependent covered by the subscriber's policy.

Ae. "Member eligibility file" means a data file containing demographic information for each individual member eligible for medical or pharmacy benefits for one or more days of coverage at any time during the reporting month.

Af. "Patient" means any person in the data set that is the subject of the activities of the claim performed by the health care provider.

Ag. "Payer" means a third-party payer or third-party administrator.

Ah. "Payment" means the actual dollar amount paid for a claim by a health insurer.

Ai. "Personal identifiers" means information relating to an individual that contains direct or indirect identifiers to which a reasonable basis exists to believe that the information can be used to identify an individual.

Aj. "Pharmacy Benefit Manager" or "PBM" means a person or entity that performs pharmacy benefit management as that term is defined at 18 V.S.A. §9471(4). The term includes a person or entity in a contractual or employment relationship with an entity performing pharmacy benefit management for a health plan.

Ak. "Pharmacy claims file" means a data file containing service level remittance information from all non-denied adjudicated claims for each prescription including, but not limited to: member demographics; provider information; charge/payment information; and national drug codes.

Al. "Prepaid amount" means the fee for the service equivalent that would have been paid for a specific service if the service had not been capitated.

Am. "Principal Investigator" means the person in charge of a project that makes use of limited use research health care claims data sets. The principal investigator is the custodian of the data and is responsible for compliance with all restrictions, limitations and conditions of use associated with the data release.

An. "Public Use Data Set" means a publicly available data set containing only the public use data elements specified in this Rule as unrestricted data elements in Appendix J.

Ao. "Reporter" means a health insurer as defined herein and at 18 V.S.A. §9410(j)(1), and shall include Voluntary Reporters as defined herein.

Ap. "Subscriber" means the individual responsible for payment of premiums or whose employment is the basis for eligibility for membership in a health benefit plan.

Aq. "Third-party Administrator" means any person who, on behalf of a health insurer or purchaser of health benefits, receives or collects charges, contributions or premiums for, or adjusts or settles claims on or for residents of this State or Vermont health care providers and facilities.

Ar. "Vermont Healthcare Claims Uniform Reporting and Evaluation System" or "VHCURES" means the Department's system for the collection, management and reporting of eligibility, claims and related data submitted pursuant to 18 V.S.A. §9410.

As. "Voluntary Reporter" includes any entity other than a mandated reporter, including any health benefit plan offered or administered by or on behalf of the federal government where such plan, with the agreement of the federal government, voluntarily submits data to the BISHCA commissioner for inclusion in the database on such terms as may be appropriate.

Section 4: Reporting Requirements

Registration and Reporting Requirements

A. VHCURES Reporter Registration. On an annual basis prior to December 31, Health Insurers shall register with the Department on a form established by the Commissioner and identify whether health care claims are being paid for members who are Vermont residents and whether health care claims are being paid for non-residents receiving covered services from Vermont health care providers or facilities. Where applicable, the completed form shall identify the types of files to be submitted per Section 5. This form shall be submitted to BISHCA or its designee. See Appendix F.

B. Third Party Administrator Registration. Any person or entity that provides third party administration services, a third party administrator or "TPA" as defined in Section 3, shall register with the Department on a form established by the Commissioner, both before doing business in Vermont and on an annual basis prior to December 31 thereafter. 18 V.S.A. §9410. See Appendix G.

C. Pharmacy Benefit Manager Registration. Any person or entity that performs pharmacy benefit management (a pharmacy benefit manager or "PBM") shall register with the Department on a form established by the Commissioner both before doing business in Vermont and on an annual basis prior to December 31. 18 V.S.A. §9421. The registration requirement includes persons or entities in a contractual or employment relationship with a health insurer or PBM performing pharmacy benefit management for a health plan with Vermont en-

rollees or beneficiaries. 18 V.S.A. §9471. See Appendix H.

D. Health Insurers shall regularly submit medical claims data, pharmacy claims data, member eligibility data, provider data, and other information relating to health care provided to Vermont residents and health care provided by Vermont health care providers and facilities to both Vermont residents and non-residents in specified electronic format to the Department for each health line of business (Comprehensive Major Medical, TPA/ASO, Medicare Supplemental, Medicare Part C, and Medicare Part D) per the data submission requirements contained in the appendices to this Rule.

E. Voluntary Reporters may, with the permission of the Commissioner, participate in VHCURES and submit medical claims files, pharmacy claims files, member eligibility files, provider data, and other information relating to health care provided to Vermont residents and health care provided by Vermont health care providers and facilities to both Vermont residents and non-residents in specified electronic format to the Department per the data submission requirements contained in the appendices to this Rule.

Section 5: Required Healthcare Data Files

Mandated Reporters shall submit to BISHCA or its designee health care claims data for all members who are Vermont residents and all non-residents who received covered services provided by Vermont health care providers or facilities in accordance with the requirements of this section. Each Mandated Reporter is also responsible for the submission of all health care claims processed by any sub-contractor on its behalf unless

such subcontractor is already submitting the identical data as a Mandated Reporter in its own right. The health care claims data submitted shall include, where applicable, a member eligibility file containing records associated with each of the claims files reported: a medical claims file and a pharmacy claims file. The data submitted shall also include supporting definition files for payer specific provider specialty taxonomy codes and procedure and/or diagnosis codes.

A. General Requirements for Data Submission

(1) Adjustment Records. Adjustment records shall be reported with the appropriate positive or negative fields with the medical and pharmacy claims file submissions. Negative values shall contain the negative sign before the value. No sign shall appear before a positive value.

(2) Behavioral or Mental Health Claims. All claims related to behavioral or mental health shall be included in the medical claims file.

(3) Capitated Service Claims. Claims for capitated services shall be reported with all medical and pharmacy claims file submissions.

(4) Claims Records. Records for the medical and pharmacy claims file submissions shall be reported at the visit, service, or prescription level. The submission of the medical and pharmacy claims is based upon the paid dates and not upon the dates of service associated with the claims.

(5) Codes and Encryption Requirements

(a) Code Sources. Unless otherwise specified in this regulation, the code sources listed and described in Appendix A shall be uti-

lized in association with the member eligibility file and medical and pharmacy claims file submissions.

(b) Member Identification Code. Reporters shall assign to each of their members a unique identification code that is the member's social security number. If a Reporter does not collect the social security numbers for all members, the Reporter shall use the social security number of the subscriber and then assign a discrete two-digit suffix for each member under the subscriber's contract.

If the subscriber's social security number is not collected by the Reporter, a version of the subscriber's certificate or contract number shall be used in its place. The discrete two-digit suffix shall also be used with the certificate or contract number. The certificate or contract number with the two-digit suffix shall be at least eleven but not more than sixty-four characters in length.

The social security number of the member/subscriber and the subscriber and member names shall be encrypted prior to submission by the Reporter utilizing a standard encryption methodology provided by BISHCA or its designee. The unique member identification code assigned by each Reporter shall remain with each member/subscriber for the entire period of coverage for that individual.

(c) Specific/Unique Coding. With the exception of provider, provider specialty, and procedure/diagnosis codes, specific or unique coding systems shall not be permitted as part of the health care claims data set submission.

(6) Co-Insurance/Co-Payment. Co-insurance and co-payment are to be reported in two separate fields in the medical and pharmacy claims file submissions.

(7) Coordination of Benefits Claims. Claims where multiple parties have financial responsibility shall be included with all medical and pharmacy claims file submissions.

(8) Denied Claims. Denied claims shall be excluded from all medical and pharmacy claims file submissions. When a claim contains both fully processed/paid service lines and partially processed or denied service lines, only the fully processed/paid service lines shall be included as part of the health care claims data set submittal.

(9) Eligibility Records. Records for the member eligibility file submission shall be reported at the individual member level with one record submitted for each claim type. If a member is covered as both a subscriber and a dependent on two different policies during the same month, two records must be submitted. If a member has 2 contract numbers for 2 different coverage types, 2 member eligibility records shall be submitted.

(10) Exceptions.

(a) Medical Claims File Exclusions. All claims related to services provided under stand-alone health care policies shall be excluded if the services are not covered by comprehensive medical insurance policies and are provided on a stand-alone basis for:

1. Specific disease;
2. Accident:
3. Injury;
4. Hospital indemnity;
5. Disability:
6. Long-term care;
7. Student liability;
8. Vision coverage; or
9. Durable medical equipment.

(b) Claims for pharmacy services containing national drug codes are to be included in the pharmacy claims file, but excluded from the medical claims file.

(c) Member Eligibility File Exclusions. Members without medical or pharmacy coverage for the month reported shall be excluded.

(11) File Format. Each file submission shall be an ASCII file, variable field length, and asterisk delimited. When asterisks are used in any field values, the entire value shall be enclosed in double quotes.

(12) Insured Group or Policy Number Key Look-up Table. Reporters are required to submit a key look-up table when submitting member eligibility files. The key look-up table shall link Insured Group or Policy Number (ME006) to the name of the group associated with each Insured Group or Policy Number, but shall not identify any individual policyholders in connection with non-group policies.

(13) Header and Trailer Records. Each member eligibility file and each medical and pharmacy claims file submission shall contain a header record and a trailer record. The header record is the first record of each separate file submission and the trailer record is the last. The header and trailer record formats shall be as detailed in Appendices B-1 and B-2.

(14) Pharmacy Claims. Claims for pharmacy services shall be included in the following files:

(a) If the pharmacy claims are covered under the medical benefit then the claim shall be included in the medical claims file and not the pharmacy claims file; and

(b) If the claim is covered under the prescription benefit then the claim shall be included in the pharmacy claims file.

(15) Prepaid Amount. Any prepaid amounts are to be reported in a separate field in the medical and pharmacy claims file submissions.

(16) Supplemental Health Insurance. Claims related to supplemental health insurance are to be included if the policies are for health care services entirely excluded by the Medicare, Tri-

care, or other publicly funded health benefit programs.

B. Detailed File Specifications.

(1) Filled Fields. All required fields shall be filled where applicable. Non-required text, date, and integer fields shall be set to null when unavailable. Non-applicable decimal fields shall be filled with one zero and shall not include decimal points when unavailable.

(2) Position. All text fields are to be left justified. All integer and decimal fields are to be right justified.

(3) Signs. Positive values are assumed and need not be indicated as such. Negative values must be indicated with a minus sign and must appear in the left-most position of all integer and decimal fields. Over-punched signed integers or decimals are not to be utilized.

(4) Individual Elements and Mapping. Individual data elements, data types, field lengths, field description/code assignments, and mapping locators (UB-04, HCFA 1500, ANSI X12N 270/271, 835, 837) for each file shall be as detailed in the following appendices:

(a) (1) Member Eligibility File Specifications – Appendix C-1

(2) Member Eligibility File Mapping to National Standard Formats – Appendix C-2

(b) (1) Medical Claims File Specifications – Appendix D-1

(2) Medical Claims File Mapping to National Standard Formats – Appendix D-2

(c) (1) Pharmacy Claims File Specifications – Appendix E-1

(2) Pharmacy Claims File Mapping to National Standard Formats – Appendix E-2

Section 6: Submission Requirements

Data submission requirements shall be as detailed in the attached appendices.

A. Registration Form. It is the responsibility of each Health Insurer to resubmit or amend the registration form required by Section 4 (A) whenever modifications occur relative to the data files or contact information.

B. File Organization. The member eligibility file, medical claims file and pharmacy claims file shall be submitted to BISHCA or its designee as separate ASCII files. Each record shall terminate with a carriage return (ASCII 13) or a carriage return line feed (ASCII 13, ASCII 10).

C. Filing Media. Files shall be submitted utilizing one of the following media: diskette (1.44 MB), CD-ROM (650 MB), DVD, secure SSL web upload interface, or electronic transmission through a File Transfer Protocol. E-mail attachments shall not be accepted. Space permitting, multiple data files may be submitted utilizing the same media if the external label identifies the multiple files.

D. Transmittal Sheet. All file submissions on physical media shall be accompanied by a hard copy trans-

mittal sheet containing the following information: identification of the Reporter, file name, type of file, data period(s), date sent, record count(s) for the file(s), and a contact person with telephone number and E-mail address. The information on the transmittal sheet shall match the information on the header and trailer records. See Appendix I.

E. Testing of Files. At least sixty days prior to the initial submission of the files or whenever the data element content of the files as described in Section 5 is subsequently altered, each Reporter shall submit to BISHCA or its designee a data set for comparison to the standards listed in Section 7. The size, based upon a calendar period of one month, quarter, or year, of the data files submitted shall correspond to the filing period established for each Reporter under subsection I of this Section.

F. Rejection of Files. Failure to conform to subsections A, B, or C of this Section shall result in the rejection and return of the applicable data file(s). All rejected and returned files shall be resubmitted in the appropriate, corrected form to BISHCA or its designee within 10 days.

G. Replacement of Data Files. No Reporter may replace a complete data file submission more than one year after the end of the month in which the file was submitted unless it can establish exceptional circumstances for the replacement. Any replacements after this period must be approved by BISHCA. Individual adjustment records may be submitted with any monthly data file submission.

H. Run-Out Period. Reporters shall submit medical and pharmacy claims files for at least a six month period following the termination of coverage date

for all members who are Vermont residents or non-residents receiving covered services provided by Vermont health care providers or facilities.

I. Data Submission Schedule. The reporting period for submission of each specified file listed in Section 5 shall be determined on a separate basis for Vermont members and non-resident members by the highest total number of Vermont resident members or non-resident members receiving covered services provided by Vermont providers or facilities for which claims are being paid for any one month of the calendar year. Data files are to be submitted in accordance with the following schedule:

Total # of Members	Reporting Period	Reporting Schedule
≥ 2,000	Monthly	Prior to the end of the month following the month in which claims were paid
500 – 1,999	Quarterly	Prior to April 30, July 31, October 31, January 31 for each preceding calendar quarter in which claims were paid
200 - 499	Annually	Prior to April 30 of the following year for the preceding twelve months in which claims were paid
< 200	N/A	

If the data files submitted by an individual Reporter support or are related to the files submitted by another Reporter, BISHCA shall establish a filing period for the parties involved.

Section 7: Compliance with Data Standards

A. Standards. BISHCA or its designee shall evaluate each member eligibility file, medical claims file and pharmacy claims file in accordance with the following standards:

(1) The applicable code for each data element shall be as identified in Appendices C-1, D-1, and E-1 and shall be included within eligible values for the element;

(2) Coding values indicating "data not available", "data unknown", or the equivalent shall not be used for individual data elements unless specified as an eligible value for the element;

(3) Member sex, diagnosis and procedure codes, and date of birth and all other date fields shall be consistent within an individual record;

(4) Member identifiers shall be consistent across files; and

(5) Files submitted shall not contain direct personal identifiers.

B. Notification. Upon completion of this evaluation, BISHCA or its designee will promptly notify each Reporter whose data submissions do not satisfy the standards for any reporting period. This notification will identify the specific file and the data elements that are determined to be unsatisfactory.

C. Response. Each Reporter notified under subsection 7.B shall resubmit within 60 days of the date of notification with the required changes.

D. Compliance. Failure to file, report, or correct health care claims data sets in accordance with the provisions of this regulation may be considered a violation of 18 V.S.A. §9410(g).

Section 8: Procedures for the Approval and Release of Claims Data

The requirements, procedures and conditions under which persons other than the Department may have access to health care claims data sets and related information received or generated by the Department or its designee pursuant to this regulation shall depend upon the requestor and the characteristics of the particular information requested, all as set forth below.

A. Classification of Data Elements

(1) Unrestricted Data Elements: Data elements designated in Appendix J as "Unrestricted" shall be available for general use and public release as part of a Public Use File.

(2) Restricted Data Elements: Data elements designated in Appendix J as "Restricted" shall not be available for use and release outside the Department except as part of a Limited Use Research Health Care Claims Data Set approved by the commissioner pursuant to the requirements of this regulation.

(3) Unavailable Data Elements: Data elements which are not designated in Appendix J as either Unrestricted or Restricted, or are designated as "Unavailable", shall not be available for release or use outside the Department in

any data set or disclosed in publicly released reports in any circumstance.

B. Public Use Data Sets: Release and Availability

(1) Unrestricted Data Elements collected or generated by the Department or its designee shall be made available in public use files and provided to any person upon written request, except where otherwise prohibited by law.

(2) The Department shall maintain a public record of all requests for and releases of public use data sets.

C. Limited Use Health Care Claims Research Data Sets- Release and Availability

(1) Limited Use Health Care Claims Research Data Sets shall be those sets which contain restricted data elements, shall not be available to the general public and shall be released to a requestor only for the purpose of research upon a determination by the Commissioner that the following conditions have been met:

(a) Application: Any person requesting access to or use of Limited Use Health Care Claims Research Data Sets shall submit an application, in written and electronic form, to the Commissioner disclosing the information listed below. Studies utilizing data sets for longer than 2 years may be required to reapply.

(1) Identity of principal investigator:

(a) Name, address, and phone number;

(b) Organizational affiliation;

(c) Professional qualification; and

(d) Phone number of principal investigator's contact person, if any.

(2) Identity of person requesting access, including any entities for whom that person is acting in requesting the data.

(a) Name, address, and phone number;

(b) Organizational affiliation;

(c) Professional qualification; and

(d) Name and phone number of contact person.

(3) Identity of and qualifications of any other persons who may have access to the data.

(4) A detailed research protocol, to include:

(a) A summary of background, purposes, and origin of the research;

(b) A statement of the health-related problem or issue to be addressed by the research;

(c) The research design and methodology, including either the topics of exploratory research or the specific research hypotheses to be tested;

(d) The procedures that will be followed to maintain the confidentiality of any data or copies of records

provided to the principal investigator or other persons; and

(e) The intended research completion date;

(5) Particular data set requested, including:

(a) The time period of the data requested;

(b) The specific data elements or fields of information required;

(c) A justification of the need for each restricted element or field, as identified in the data release schedule;

(d) The minimum needed specificity of the requested data elements, including the manner in which the data may be recoded by the department to be less specific;

(e) The selection criteria for the minimum needed data records required; and

(f) Any particular format or layout of data requested by the principal investigator.

(6) Any changes to information submitted as part of an application pursuant to (a)(1)-(4) shall require notice to the Department by the applicant and shall be subject to the approval of the Commissioner.

(b) The person or entity requesting access and the principal investigator or investigators shall be subject to the following requirements and limitations and shall, in addition, sign and submit a data use agreement acknowledging and accepting these same provisions as a necessary condition to any data access:

(1) Use of data for any purpose other than as specified in the application and approved by the Commissioner shall be prohibited;

(2) Appropriate safeguards to protect the confidentiality of the data and prevent unauthorized use of the data shall be established;

(3) The use or disclosure, sale, or dissemination of the data set or statistical tabulations derived from the data set to any person or organization for any purpose other than as described in the application and as permitted by the data use agreement shall be prohibited without the express written consent of the Commissioner.

(4) The use or disclosure, sale, or dissemination of any information contrary to law shall be prohibited;

(5) No person shall disclose the identity of patients, employer groups or purchaser groups from information contained in the limited use data set;

(6) No person shall disclose any of the information that has been encrypted or removed from the data;

(7) The content of cells that contain counts of persons in statistical tables in which the cell size is more than 0 and less than 5 shall not be disclosed, published or made public in any manner except as "<5";

(8) The publication, dissemination or disclosure of any information that could be used to identify providers of abortion services shall be prohibited;

(9) Any use or disclosure of the information that is contrary to the Data Use Agreement or this Regulation shall be reported to the Department within five (5) days of when the principal investigator becomes aware of such disclosure.

(10) The Department and the "Vermont Healthcare Claims Uniform Reporting and Evaluation System" shall be acknowledged as the source and owner of the data in any and all public reports, publications, or presentations generated from the data;

(11) Written materials shall prominently state that the analyses, conclusions and recommendations drawn from such data are solely those of the requestor or principal investigator and are not necessarily those of the Department;

(12) The Department shall be provided with a copy of any proposed report or publication containing information derived from the data at least 15 days prior to any publication or release to allow the department to review the proposed report or publication and confirm that the conditions of the agreement have been applied. When multiple reports of a similar nature will be created from the data, the Department may, on request, waive the requirement that any subsequent reports or publications be provided to the Department prior to release by the requesting party

(13) Data elements shall not be retained for any period of time beyond that necessary to fulfill the requirements of the data request.

(14) Within 30 days after the scheduled completion date of the project, the requestor shall delete, destroy or otherwise render the data unreadable, so certifying by submitting a written notice to the Department or by reapplying for approval if the end date of the project needs to be extended;

(15) Any draft reports or publications supplied to the department shall be considered confidential and exempt from public review under 1 V.S.A. §315 et seq. and shall not be released by the Department; and

(16) Failure to adhere to the data use agreement or the limitations and restrictions detailed above will be cause for immediate recall by the Department of the data, revocation of permission to use the data, and grounds for civil or administrative enforcement action by the Department under applicable Vermont state law.

(c) The Department shall establish a claims data release advisory committee with a chair person and members appointed annually by the Commissioner, to provide nonbinding advice and opinion to the Commissioner, as and when requested, on the merits of applications for access to limited use data sets. If the Commissioner has requested a review of the application, the claims data release advisory committee shall provide the Commissioner with any comment on the merits of the application and the research protocol described therein within thirty (30) days. The committee shall be comprised of seven (7) members and include:

(1) At least one member representing health insurers;

(2) At least one member representing health care facilities;

(3) At least one member representing health care providers;

(4) At least one member representing purchasers of health insurance or health benefits; and

(5) At least one member representing healthcare researchers.

(2) The Commissioner may approve the release of limited use data sets only when the Commissioner is satisfied as to the following:

(a) The application submitted is complete and the requesting individuals or entities and principal investigator have signed a data use agreement as specified;

(b) Procedures to ensure the confidentiality of any patient and any confidential data are documented;

(c) The qualifications of the investigator and research staff, as evidenced by:

(1) Training and previous research, including prior publications; and

(2) An affiliation with a university, private research organization, medical center, state agency, or other qualified institutional entity.

(d) No other state or federal law or regulation prohibits release of the requested information.

(3) If the Commissioner declines to release the requested limited use data sets within 60 days of receipt of a complete application, the Department shall give written notice of the basis for denial of the application and the requestor shall have leave to resubmit or supplement the ap-

plication to address the Commissioner's concerns. Any adverse decision regarding an application may be appealed within 30 days by filing a request for hearing with the Commissioner pursuant to Department Rule 82-1.

Section 9: Prices for Data Sets, Fees for Programming and Report Generation, Duplication Rates

This Section lists the prices for data sets from the Vermont Healthcare Claims Uniform Reporting and Evaluation System, including the fees for programming and report generation, duplicating charges and other costs associated with the production and transmission of data sets approved for release by the Department.

A. An annual public use file consisting of unrestricted fields and data elements shall be made available to any person upon request at the cost required for the Department to process, package and ship the data set, including any electronic medium used to store the data.

B. Limited Use Research Health Care Claims Data Sets approved by the Department shall be made available to the requesting party at the cost charged by the Department's designated vendor to program and process the requested data extract, including any consulting services and costs to package and ship the data set on particular electronic medium.

C. Payments are due in full from the requesting party within thirty days of receipt of BISHCA data sets, files, reports, or other released material.

Section 10: Enforcement

Violations of data submission requirements, confidentiality requirements, data use limitations or any other provisions of this rule shall be subject to sanction by the Commissioner as set out in 18 V.S.A. §9410 in addition to any other powers granted to the Commissioner to investigate, subpoena, fine or seek other legal or equitable remedies.

Section 11: Severability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provisions to other persons or circumstances shall be not affected thereby.

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In The
Supreme Court of the United States

ALFRED GOBEILLE, in his official capacity as chair of the Vermont Green Mountain Care Board,
Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,
Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

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INTRODUCTION

This Court's precedents, including *Travelers* and *De Buono*, recognize that Congress did not intend ERISA to displace state health care regulation. Vermont's health care database law falls squarely within that historical, non-preempted state role: it is "designed to improve the quality, utilization, and cost of healthcare in Vermont by providing consumers, government officials, and researchers with comprehensive data about the healthcare-delivery system." U.S. Br. 11. To do their jobs effectively, regulators and policymakers need accurate information about health care expenditures. Those critical health care spending data are necessarily held by a wide range of payers, including federal and state government programs, private insurers, and third-party administrators of ERISA plans. Vermont's collection of claims data from all payers through a generally applicable health care law does not intrude on the areas that ERISA reserves to federal law.

Liberty Mutual's brief says little about the Court's controlling decisions in *Travelers* and *De Buono* or state authority to regulate health care. Instead, Liberty Mutual argues that providing claims data is unacceptably burdensome for plans. This Court, however, has held that incidental burdens and administrative costs for ERISA plans are insufficient to warrant preemption of a generally applicable state health care law. In any event, despite the pages Liberty Mutual devotes to this point, the record is silent. Even after prodding by the district court in this case, Liberty Mutual was unable to produce any evidence of cost or burden—and there is none.

The strong showing of *amicus* support for Vermont's law from States, policymakers, health care providers,

and researchers highlights the importance of these comprehensive health care databases. They provide the information needed to grapple with the complexity and cost of our nation's health care system. They support policies and research that improve patient care and outcomes. And they serve not just state purposes, but federal objectives as well. Liberty Mutual has not shown that preemption is warranted here.

I. This Court's established precedents confirm that Vermont's health care database statute is not preempted.

The principles set forth in *Travelers*, *De Buono*, and related precedent control the analysis here and require reversal of the decision below. Liberty Mutual's bare acknowledgement of the Court's central decisions addressing ERISA preemption and state health care laws highlights the weakness of its position. And the new rule for preemption that Liberty Mutual offers—that States are preempted from gathering any information from self-insured plans that relates to the provision of benefits—is not supported by ERISA's text, its legislative history, or this Court's decisions.

A. Liberty Mutual disregards the Court's settled framework for ERISA preemption.

Under the framework this Court adopted in *Travelers* and re-affirmed in *De Buono* and *Dillingham*, Vermont's database statute is not preempted.[1] The

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[1] Respondent's *amici* argue that the Court should overrule *Travelers* and adopt new tests for ERISA preemption. *See* BCBSA Br. 4-18; New England Legal Found. Br. 3-12. As the parties have not argued that the Court should overrule its precedents, the issue is not properly before the Court. *See, e.g.*, *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2776

Court confronted in *Travelers* precisely the question raised by this case: did Congress intend ERISA to broadly preempt state health care regulations? The Court concluded that "nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. 645, 661 (1995). Vermont's all-payer claims database (APCD) regulates health care, not employee benefit plans, and it does not intrude on ERISA's core objectives. It is not preempted.

1. The United States agrees, and Liberty Mutual does not dispute, that Vermont's statute "operate[s] in the traditional state sphere of health and safety." U.S. Br. 11. States use these databases to design strategies to control costs while improving the quality of care; support health care research; regulate insurers and providers; and evaluate and improve public health policy. *See* Pet. Br. 12-16, 31-35.[2] Because

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(2014). In any event, *amici* do not offer a credible argument for overturning this longstanding body of precedent. *Stare decisis* has "special force" in the context of statutory interpretation, because "Congress remains free to alter" what the Court has decided. *John R. Sand & Gravel Co. v. United States*, 552 U.S. 130, 139 (2008) (quotations omitted). In the 20 years since *Travelers*, the Court has re-affirmed its holding and Congress has not modified the Court's interpretation of ERISA's preemption clause. *See Watson v. United States*, 552 U.S. 74, 82-83 (2007) (relying in part upon "long congressional acquiescence" over 14-year period as support for applying *stare decisis*); *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000) (re-affirming *Travelers* standard).

[2] *See also, e.g.*, U.S. Br. 16 (database serves "variety of general healthcare related goals"); N.Y. Br. 12-20 (providing examples related to public health, insurance regulation, transparency, and cost control); NGA Br. 10-14 (similar); N.H. Br. 14-

the database statute "operates in a field that has been traditionally occupied by the States," Liberty Mutual bears a "considerable burden" to establish preemption. *De Buono*, 520 U.S. 806, 814 (1997) (quotations omitted). "[I]n the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Pegram*, 530 U.S. at 237

2. Requiring third-party administrators, like all health care payers, to provide standardized paid claims data to Vermont's database does not intrude on ERISA's core objectives. Those objectives, distilled from the statute's text and this Court's precedents, are: (i) protecting beneficiaries by establishing fiduciary standards and ensuring plans pay promised benefits; (ii) creating an exclusive federal enforcement mechanism; and (iii) establishing a uniform body of federal law governing the provision and funding of benefits. Pet. Br. 25-29. State APCDs—which collect claims data from all payers to gain a comprehensive picture of health care spending—serve purposes unrelated to these core ERISA objectives. And APCD laws have no impermissible effect on plans because plan administrators generate claims data in the ordinary course of business. Collecting this after-the-fact data does not insert the State into the plan's operations or into the relationship between a plan and its members.

Preemption does not occur simply because a generally applicable law has some effect on a plan—here, by requiring the plan to provide the same data as other health care payers. The Court repeatedly has upheld state laws that affect plans but do not regu-

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19 (insurance regulation); CHLPI Br. 13 (research that "directly impacted patient care").

late the core areas that ERISA reserves to federal law. In *Mackey*, the Court upheld the application of state garnishment statutes to ERISA plans, over the objection that garnishment proceedings involved "substantial administrative burdens and costs." 486 U.S. 825, 831 (1988). As the Court later explained, it "took no issue" with the claim that garnishment would impose "costs and burdens upon benefit plans" but held that Congress nonetheless did not intend to preempt state laws that impose "an indirect source of administrative cost." *Travelers*, 514 U.S. at 662 (citing *Mackey*, 486 U.S. at 831-32).

In *Travelers*, building upon *Mackey*, the Court upheld New York's hospital-rate surcharges, which required hospitals to charge commercial insurers (including insured ERISA plans) 24% more than Blue Cross/Blue Shield payers. *Id.* at 650, 668. *De Buono* sustained a state tax on gross receipts of health care facilities, as applied to facilities directly operated by ERISA plans. 520 U.S. at 809-10. The Court recognized that the tax increased the cost of providing benefits and had "some effect on the administration of ERISA plans," but, the Court emphasized, "that simply cannot mean that every state law with such an effect is pre-empted." *Id.* at 816. And, in *Dillingham*, the Court held that California's prevailing wage law was not preempted by ERISA, even though ERISA apprenticeship plans were put to the choice of complying with state-law standards or paying a higher wage to apprentices. 519 U.S. 316, 332-34 (1997).

These decisions confirm that, despite the breadth of ERISA's preemption clause, Congress intended neither to insulate plans from all state regulation nor to displace "traditionally state-regulated substantive

law" in areas where ERISA "has nothing to say." *Id.* at 330; *see also De Buono*, 520 U.S. at 815 (describing tax as "one of myriad state laws of general applicability that impose some burdens on the administration of ERISA plans" but are not preempted) (quotations omitted). Vermont's law stays well clear of ERISA's concerns because it does not regulate how plans operate *as plans*. The Court has described an ERISA "plan" as a "scheme decided upon in advance" that "comprises a set of rules that define the rights of a beneficiary and provide for their enforcement." *Pegram*, 530 U.S. at 223. The "provisions that constitute a plan" include "[r]ules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services." *Id.* The database statute does not regulate these matters and does not define the rights of beneficiaries or provide for their enforcement. It is not preempted.

B. Liberty Mutual's cursory effort to distinguish controlling precedent is unpersuasive.

1. Instead of grappling with the Court's reasoning in *Travelers* and *De Buono*, Liberty Mutual tries (at 53) to distinguish the cases on their facts, asserting that Vermont's statute "has an entirely different focus" from health care surcharges and taxes. In fact, both *Travelers* and *De Buono* involved much broader state health policy goals. *See De Buono*, 520 U.S. at 809 (noting that New York imposed tax on gross receipts for health care facilities to address Medicaid deficit); *Travelers*, 514 U.S. at 658-59 (describing policy bases for surcharges on commercial insurers and HMOs). The Court in *Travelers* recognized this broader context, noting that "Congress

never envisioned ERISA pre-emption as blocking state health care cost control, but rather meant to encourage and rely on state experimentation like New York's." 514 U.S. at 667 n.6.

APCDs, like the taxes and surcharges upheld in *Travelers* and *De Buono*, are tools that States use to manage their health care systems better and more efficiently. Indeed, databases are closely suited to this task, because they "provide policymakers with information they can use to develop programs that improve the quality of health care while controlling costs." N.Y. Br. 10. The Court's reasoning in *Travelers* and *De Buono* applies with equal force to state health care databases.

Liberty Mutual mistakenly implies (at 54) that the regulations upheld in *Travelers* and *De Buono* had little relevance to plans, and applied to them only by "happenstance." Not so. The hospital-rate surcharge upheld in *Travelers* applied to the benefit payments made by insured plans—that is, plans insured by commercial insurers paid 24% more for the same services than Blue Cross carriers paid. 514 U.S. at 650.[3] That surcharge—partly a tax turned over to the State—thus affected how insured plans paid for employee health benefits. Similarly, in *De Buono*, the Court upheld a tax on health care services as applied to plan-run health care facilities. 520 U.S. at 809-10. That tax applied directly to the plan's provision of benefits to its members. These state taxes and surcharges were upheld notwithstanding their effects on benefit plans, because Congress did

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[3] In *Travelers*, the Blue Cross entities opposed preemption, relying on the "strong presumption against preemption where the challenged law was based upon the states' traditional police powers." Pets. Br. 28, *Travelers*, 514 U.S. 645 (No. 93-1408).

not intend ERISA to override ordinary state health care regulations. *See id.* at 813-16; *Travelers*, 514 U.S. at 654-55, 661-62, 664-67.

2. Liberty Mutual's alternative argument (at 44-47) that providing claims data to Vermont conflicts with 29 U.S.C. § 1104(a)(1)(D)—which requires plan fiduciaries to act "in accordance with the documents and instruments governing the plan"—also lacks merit. As the United States has shown, complying with Vermont's law does not conflict with Liberty Mutual's plan documents. *See* U.S. Br. 32-34. Indeed, the primary plan document, which controls plan terms, says the plan will comply with "state and federal law to the extent not preempted by ERISA." JA57.

In any event, the Court has rejected the argument that § 1104(a)(1)(D) preempts any state law that may be contrary to a plan term. *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, 375-76 (1999). Although, as Liberty Mutual notes (at 45), *UNUM* was decided under ERISA's savings clause for laws relating to insurance, the Court's holding did not turn on the language of that clause but on the illogic of the argument. *Id.* The scope of state regulatory authority cannot depend, plan by plan, on provisions that employers choose to include in plan documents.

Nor does *Egelhoff* support Liberty Mutual's alternative argument. There, the Court held preempted a state law that overrode the plan terms governing beneficiary designations. That "implicate[d] an area of core ERISA concern," because administrators would have to "pay benefits to the beneficiaries chosen by state law, rather than to those identified in the plan documents." 532 U.S. 141, 147 (2001). Nothing in *Egelhoff* suggests that plans can expand

ERISA preemption and circumvent otherwise applicable state law merely by including contrary language in plan documents.

C. Liberty Mutual's proposed new test is not supported by ERISA's text or legislative history and cannot be reconciled with this Court's precedents.

Rather than address controlling precedent or defend the approach taken by the decision below, Liberty Mutual offers a new test, arguing that ERISA preempts any state-law requirement that plans provide information touching upon the provision of benefits. Liberty Mutual relies heavily on selected excerpts from ERISA's extensive legislative history. But neither ERISA's text nor its legislative history supports Liberty Mutual's position. And the rule it proposes cannot be reconciled with *Mackey*, *Travelers*, *De Buono*, and *Dillingham*.

1. Liberty Mutual's proposed test relies (at 13) on the premise that one of Congress's "principal objectives" in passing ERISA was to reduce reporting burdens on plans. This suggestion that ERISA's reporting and disclosure standards were intended to reduce *all* administrative burdens finds no support in the statute's text. ERISA's reporting requirements are "extensive" and "elaborate." *Dillingham*, 519 U.S. at 327; *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 139 n.7 (1985). And ERISA's text confirms that its reporting requirements were intended to protect beneficiaries, not to lighten administrative burdens. *See* 29 U.S.C. § 1001(b) (declaring policy to protect "the interests of participants in employee benefit plans and their beneficiaries" in part by requiring "disclosure and reporting . of financial and other information"); *id.* § 1001(a) (noting "lack

of employee information and adequate safeguards concerning [plan] operation"; need for "disclosure" and "safeguards"; and concerns with "soundness and stability of plans" and loss of anticipated benefits). The reporting and disclosure provisions require information about plan financing, actuarial soundness, adherence to fiduciary standards, and participants' rights—information regulators and participants need to ensure that plans are managed appropriately. *See id.* §§ 1021-1025. This Court repeatedly has recognized that ERISA's reporting, disclosure, and fiduciary requirements were intended to protect beneficiaries from mismanagement and failure to pay benefits. *See Dillingham*, 519 U.S. 326-27; *Morash*, 490 U.S. 107, 115 (1989).

Neither Vermont nor the federal government has suggested that ERISA leaves States generally "free to impose their own reporting requirements." Resp. Br. 16. Rather, the nature and purpose of ERISA's reporting requirements guide the preemption inquiry. Requirements that "effectively invade the field exclusively governed by ERISA and alter the approach that Congress adopted to ensure that plans are administered according to appropriate legal requirements" are preempted. U.S. Br. 16; *see* Pet. Br. 22-23. Collecting standardized data on paid health claims to serve traditional state purposes, however, falls comfortably outside the field that ERISA governs.[4]

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[4] The Affordable Care Act's (ACA) "technical amendment" to Part 7 of ERISA does not change the analysis. *See* Pub. L. No. 111-148, § 1562(e), 124 Stat. 119, 270 (codified at 29 U.S.C. § 1185d). The ACA amended ERISA to incorporate a number of the ACA's market reforms, including requirements that health plans report on their finances, claims policies, and how their

2. Liberty Mutual's selective citation to ERISA's voluminous legislative history is unconvincing. Much of what Liberty Mutual culls from predecessor bills and members' statements shows merely that Congress intended a significant degree of federal preemption and wanted plan reporting, disclosures, and fiduciary standards to be governed by federal law. Neither proposition is disputed—and neither decides this case. Moreover, Liberty Mutual's recounting of legislative history is flawed in several key respects.

First, ERISA's legislative history confirms that the reporting and disclosure requirements were intended to protect and inform beneficiaries. *See* AARP Br. 15-18. Even Liberty Mutual's excerpts show that Congress treated plan reporting as linked with other aspects of plan governance, including funding, fiduciary standards, and disclosures. *See, e.g.*, S. Rep. No. 93-127, at 35 (1973) (addressing "single reporting and disclosure system" together with standards for "vesting, funding, insurance and portability standards,

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benefits comply with the ACA's coverage goals. *Id.* §§ 1001, 1562(e), 10101, 124 Stat. 130-38, 270, 883-91; *see also* 42 U.S.C. §§ 300gg-15a, 300gg-17, 300gg-18. *Amicus* Blue Cross and Blue Shield Association mistakenly argues (at 21-28) that this amendment expands ERISA preemption. *First*, like ERISA's reporting and disclosure provisions, the ACA amendment ensures that plans fulfill their benefit promise—including by providing ACA-mandated coverage. *Second*, the ACA states "[n]othing in [Title I, which includes the relevant provisions,] shall be construed to preempt any State law that does not prevent the application of [Title I]." 42 U.S.C. § 18041(d). And, *finally*, Part 7 of ERISA—which now incorporates the new provisions—expressly provides that "[n]othing in this part shall be construed to affect or modify the provisions of" § 1144 "with respect to group health plans." 29 U.S.C. § 1191(a)(2); *see also* U.S. Br. 21-22.

[and] evaluating fiduciary conduct"), *reprinted in* 1974 U.S.C.C.A.N. 4838, 4871; S. 3589, 91st Cong. § 14 (1970), *in* 116 Cong. Rec. 7284 (1970) (prior bill, addressing preemption of "fiduciary, reporting and disclosure responsibilities"). The statement from Senator Javits, which Liberty Mutual edits (at 19), described the preempted "field of private employee benefit programs":

> In view of Federal preemption, State laws compelling disclosure from private welfare or pension plans, imposing fiduciary requirements on such plans, imposing criminal penalties on failure to contribute to plans—unless a criminal statute of general application—establishing State termination insurance programs, et cetera, will be superseded. It is also intended that a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans.

120 Cong. Rec. 29,942 (1974). This fuller context illustrates why Liberty Mutual's reading of legislative history is flawed. Comments like these do not suggest Congress intended to preempt state health care regulations unrelated to plan governance.

Second, although some legislators may have questioned the wisdom of dual regulation by the Departments of Labor and Treasury, the debate over agency roles involved much broader political issues.[5] And, regardless, Congress did not centralize plan oversight in one agency. ERISA instead exhorted

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[5] *See generally* James A. Wooten, *Employment Retirement Income Security Act of 1974: A Political History* 178, 185-89, 200-05, 250-51 (2004) (discussing competing views of labor and business interests and committee-jurisdiction issues related to agency oversight).

both agencies to "consult" and adopt rules and practices that "reduce duplication . . . of reporting" to "the extent appropriate." 29 U.S.C. § 1204(a). Further, the text conveys concern with the cost to the federal government, not just to plans. *See id.* § 1204(b) (affording discretion to cooperate "to avoid unnecessary expense and duplication of functions among Government agencies"). Given that resolution, the issue hardly warrants the emphasis Liberty Mutual places on it.

Third, Liberty Mutual's assertion (at 23) that Congress "clearly considered" claims data to be part of plan reporting far outstrips anything Liberty Mutual cites from ERISA's text or legislative history. The standardized electronic claims data that APCDs collect did not exist in 1974. Liberty Mutual also places substantial weight on what seems to be a misreading of ERISA's legislative history, suggesting (at 23) that Congress viewed "claims information" as "extremely burdensome" to provide and amended the proposed bill to remove the requirement to report total benefits paid by the plan. ERISA has always required an annual "statement of receipts and disbursements . . . aggregated by general sources and applications." Pub. L. No. 93-406, § 103(b)(3)(B), 88 Stat. 829, 844 (codified at 29 U.S.C. § 1023(b)(3)(B)).[6]

In any event, draft bills and committee reports have far less relevance than contemporaneous federal statutes that acknowledged and promoted States' health data collection and States' broader role in

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[6] *See* Dep't of Labor, Form 5500, Schedule H (requiring reporting of "[t]otal benefit payments"), http://www.dol.gov/ebsa/pdf/2014-5500-Schedule-H.pdf; *id.*, Schedule I (similar), http://www.dol.gov/ebsa/pdf/2014-5500-Schedule-I.pdf; *see also* U.S. Br. 2 (noting certain reporting exemptions for welfare plans).

regulating the health care market. The same Congress that enacted ERISA also passed the Health Services Research, Health Statistics, and Medical Libraries Act of 1974. The Act (which Liberty Mutual does not discuss) formally established the National Center for Health Statistics and directed the Center to support and cooperate with state agencies. Pub. L. No. 93-353, §§ 104, 105, 88 Stat. 362, 364-66 (codified as amended at 42 U.S.C. § 242k). That law confirms that Congress both saw a need for data on health care costs, financing, and utilization, and expected the federal government to work with state government to collect those data. *See id.* If there were any doubt on that point, that same Congress also passed the National Health Planning and Resources Development Act of 1974. That statute, as the Court recognized in *Travelers*, supported States' health care planning and regulation and funded regional agencies responsible for collecting health care data. Pub. L. No. 93-641, §§ 1521-1526, 88 Stat. 2225, 2242-50 (1975); *Travelers*, 514 U.S. at 665-67. Given this contemporaneous evidence of congressional views, ERISA should not be interpreted to bar States from collecting comprehensive health care data.

3. Liberty Mutual's sweeping rule—that any state reporting requirement related to a plan's provision of benefits is preempted—cannot be reconciled with this Court's precedents. The plan-run facilities in *De Buono* provided medical care to members—a plan function expressly contemplated by ERISA. *See* 520 U.S. at 810; 29 U.S.C. § 1002(1). New York's tax on their gross receipts was directly tied to the provision of benefits and necessarily would have required reporting for calculating and enforcing the tax. The garnishment statute in *Mackey* required plans not

only to provide information about benefits, but to pay into court "funds due the beneficiary-debtor—funds that otherwise they are required to hold and pay out" to beneficiaries. 486 U.S. at 831. And garnishment was triggered by "an activity that is the essence of an employee welfare benefit plan," Resp. Br. 24—namely, providing benefits. While *Dillingham* did not directly address reporting requirements connected to prevailing wage statutes, courts of appeals have declined to hold prevailing wage laws preempted based on their recordkeeping mandates.[7]

Because ERISA contemplates that plans may offer a range of benefits, including health care, day care centers, training programs, scholarship funds, and legal services, 29 U.S.C. § 1002(1), Congress could not have intended to preempt *all* reporting requirements that reflect or touch on plan benefits. Not even Liberty Mutual supposes that Congress intended employer-run day care centers or hospitals to be unlicensed and unregulated. *See* Resp. Br. 54. But its argument that these plan-run facilities are not engaged in the "core plan activity of providing benefits," *id.*, conflicts with ERISA's text, which contemplates plans providing those very services "through the purchase of insurance *or otherwise*." 29 U.S.C. § 1002(1) (emphasis added); *see also id.* § 1191b(b)(1) (defining "health insurance coverage" under ERISA as medical care "provided directly, through insurance

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[7] *See, e.g., WSB Elec., Inc. v. Curry*, 88 F.3d 788, 795 (9th Cir. 1996) (upholding prevailing wage statute, over objection that employer would be obligated to keep "detailed" records showing benefit contributions); *Keystone Chapter, Assoc. Builders & Contractors, Inc. v. Foley*, 37 F.3d 945, 962-63 (3d Cir. 1994) (similar).

or reimbursement, or otherwise"). Liberty Mutual's rule is unworkable.

Travelers, *De Buono*, *Mackey*, and *Dillingham* articulate a central principle: that administrative burdens are not a sufficient basis for insulating ERISA plans from ordinary state regulations in fields, like health care and wage laws, "where ERISA has nothing to say." *Dillingham*, 519 U.S. at 330. Liberty Mutual seeks to transform the reporting of information into a special kind of administrative burden that triggers preemption. As text, legislative history, and precedent show, however, ERISA mandates uniform plan reporting and disclosure requirements that serve the statute's purposes. It does not bar States from obtaining information from plans.

II. Providing standardized, after-the-fact claims data does not interfere with uniform plan administration or otherwise burden plans in a manner that warrants preemption.

Liberty Mutual and its *amici* argue that the burden of complying with Vermont's database law warrants preemption. Generally applicable health care laws are not preempted simply because they "impose some burdens on the administration of ERISA plans." *De Buono*, 520 U.S. at 815; *Dillingham*, 519 U.S. at 334; *Travelers*, 514 U.S. at 668. To the contrary, preemption will be found only if the burden is so substantial that it interferes with a plan's ability "to establish a uniform administrative scheme . . . to guide processing of claims and disbursement of benefits," *Egelhoff*, 532 U.S. at 148 (quotations omitted), or forces the plan "to adopt a certain scheme of substantive coverage," *Travelers*,

514 U.S. at 668. Liberty Mutual has not come close to making that showing.

First, Liberty Mutual submitted no evidence that complying with Vermont's database law would affect the administration of its medical plan. Below, Liberty Mutual argued that evidence of the actual cost or burden of complying with Vermont's database statute was irrelevant. *See* Pet. Br. 54. The district court questioned this point at the summary judgment hearing, noting that "there doesn't seem to be a whole lot of information" on the potentially "fundamental question: How burdensome is this on Blue Cross-Blue Shield to turn over this information?" C.A. JA356. Liberty Mutual's counsel insisted that "the extent of the burden . . . doesn't matter" and that the district court did not "have to weigh the relevant burden." C.A. JA356-57. Liberty Mutual thus made no evidentiary showing, despite multiple opportunities to do so. *See, e.g.*, App. 39 (Straub, J., dissenting) (Liberty Mutual "failed to provide any details or showing of the alleged burden"); JA5 (docket showing post-hearing submission addressing other issues).

Liberty Mutual did not merely fail "to quantify the administrative costs" associated with complying with the Vermont database law. Resp. Br. 42-43. It failed to show that providing the requested data would interfere with its ability to create a uniform system for processing claims and disbursing benefits. *See Egelhoff*, 532 U.S. at 148; *Travelers*, 514 U.S. at 668. Even with its pages of argument in this Court about burdens, data elements, and formatting, Liberty Mutual still has not explained how providing the data is anything other than a potential administrative cost for its third-party administrator.

Second, *Travelers* and *De Buono* foreclose Liberty Mutual's argument (at 34-43) that the mere "threat" of an economic burden resulting from different state data-collection standards suffices to preempt Vermont's law. Those decisions upheld state health care programs notwithstanding the burdens they imposed on self-funded plans. Those decisions also established a rule of law under which the other 49 States might pursue analogous programs that imposed similar—though not necessarily identical—burdens. Liberty Mutual's proposed "threat" test is an effort to avoid the Court's controlling precedent and litigate here the APCD laws of other States, which have not been challenged by Liberty Mutual (or any other ERISA plan). *Travelers* does not require States to adopt identical regulations to avoid preemption.

Third, Vermont seeks standardized data on paid claims, which Liberty Mutual's third-party administrator generates in the ordinary course of business and could easily provide. AMA Br. 27; AHA Br. 21-22; CHLPI Br. 10-11; NAHDO Br. 5-11; NGA Br. 14-15; N.H. Br. 21, 27; N.Y. Br. 32-33; *see also* App. 39 (Straub, J., dissenting) ("The Vermont statute asks for after-the-fact information which plan administrators . . . already have in their possession") (citing Argument Tr. 7-8). The Health Insurance Portability and Accountability Act of 1996 "standardize[d] electronic transactions between payers and health care providers." NAHDO Br. 5-6. Vermont follows this "common set of industry-driven technical standards" adopted by the federal government. *Id.*; *see* 45 C.F.R. §§ 162.100-162.1902. "[U]se of nationally standardized codes and formats" makes "producing the claims data a minimal (or no) burden." AHA Br. 21. Liberty

Mutual belittles this standardization by noting (at 33 & n.10) that some data elements lack a nationally standardized code. But Liberty Mutual names several data elements for which Vermont has set the submission "threshold" at zero—meaning that submitted records need not include those elements. *See, e.g.*, Onpoint Health Data, *VHCURES Data Submission Guide* 41, 52 (2015), http://www.onpointhealthdata.org/clients/vhcures/docs/onpoint_vhcures_dsg_v20.pdf. Similarly flawed contentions by respondent's *amici* underscore Liberty Mutual's failure to submit relevant evidence in the district court.[8]

Liberty Mutual's third-party administrator, Blue Cross Blue Shield of Massachusetts, provides the requested data as an insurer and for other plans that it administers. *See* Pet. Br. 54-55. It is a primary contributor to the Massachusetts APCD, and its own payment models rely on claims data.[9] And *amicus*

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[8] The Blue Cross and Blue Shield Association, for example, includes a "rough" chart purportedly showing that yet-to-be-implemented ACA reporting requirements "sometimes" overlap or conflict with the database law. BCBSA Br. 26-28. As discussed above (at note 4), the ACA did not expand ERISA preemption. Moreover, the chart is not accurate; it lists items not part of VHCURES or with "0%" thresholds. *See, e.g.*, *VHCURES Data Submission Guide* 52 (setting "coinsurance amount" threshold at 0%). Another *amicus* speculates the database law would burden multi-employer plans that do not collect all requested data elements, but does not identify any such plan even covered—much less burdened—by the law. NCCMP Br. 12-13. In any event, the State regularly grants exceptions "when a payer's system does not collect a required element or has special considerations based on the population that they serve." *VHCURES Data Submission Guide* 12.

[9] *See* Ctr. for Health Info. and Analysis, *Overview of Massachusetts All-Payer Claims Database* 2 (2014), https://www.apcdcouncil.org/sites/apcdcouncil.org/files/media/state/ma-apcd-overview-2014.pdf; Blue Cross Blue Shield of Massachusetts,

Blue Cross and Blue Shield Association recently announced that its members will submit "comprehensive data on healthcare quality and costs," including data on $350 billion in annual claims, to a new database project.[10] That initiative is consistent with the Association's acknowledgement that its members enjoy "economies of scale" that "make compliance more streamlined," BCBSA Br. 33—and sharply undermines its assertion that submitting claims data is burdensome.

Liberty Mutual incorrectly asserts (at 56-67) that its use of a third-party administrator is irrelevant to the preemption inquiry. Liberty Mutual argues that Vermont's database law interferes with its ability to administer its medical plan. Yet its third-party administrator could easily and inexpensively provide the requested data. Compliance would not affect how Liberty Mutual provides health insurance to its employees.

Lastly, Liberty Mutual unpersuasively suggests that the Court should disregard the purpose of Vermont's law. Resp. Br. 30 ("[P]etitioner and the United States err by attempting to distinguish

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The Alternative QUALITY Contract 2, 8 (2010) ("global payment model" will be evaluated using "claims data"), http://www.bluecrossma.com/visitor/pdf/alternative-quality-contract.pdf.

[10] Press Release, Blue Cross Blue Shield Ass'n (Sept. 24, 2015), http://www.bcbs.com/healthcare-news/bcbsa/bcbsa-announces-industry-leading-healthcare-data-capability-to-drive-improved-quality-and-affordable-care.html. The Association plans to do "big things with big data," supporting "quality and cost improvement and further accelerating the movement toward smart, data-driven healthcare." Connecting the Dots with Data, http://www.bcbsaxis.com/#video-feature. That effort is not mentioned in its *amicus* brief. *See* BCBSA Br. 29 (describing submitting data as "time-consuming" and "resource-intensive").

between the purpose of the State law and the federal regulations."). *Travelers* rejects that position. *See* 514 U.S. at 658 (noting that both "purpose and effects" of the state law distinguished it from statutes that were preempted); *id.* at 659 (describing policy motivating state surcharges and noting that "their effects follow from their purpose"). Ignoring *Travelers*, Liberty Mutual relies (at 30-31) on *Gade v. National Solid Wastes Management Association*, 505 U.S. 88 (1992), and *Perez v. Campbell*, 402 U.S. 637 (1971). But those cases confirm that state purpose must be considered. *Gade*, 505 U.S. at 105 ("part of the pre-empted field is defined by reference to the purpose of the state law in question") (quotations omitted); *Perez*, 402 U.S. at 654 (finding conflict preemption because both the "declared purpose" and the effect of the state law "frustrat[ed] federal law"). In any event, as discussed above, Liberty Mutual has provided no evidence that the database law has any discernible effect on its ability to administer its medical plan.

III. Congress did not intend to displace state health care programs that improve public policy and allow States to do a better job of protecting public health and managing their health care systems.

States, the federal government, public health officials, insurance regulators, doctors, hospitals, and medical researchers have all conveyed to the Court that state health care databases are critical tools for improving public health and developing sound public policy. Echoing Vermont's opening brief, this broad showing of *amicus* support highlights three factors that weigh decisively against preemption.

First, state APCDs "continue and improve a long-standing practice of using health data collection to supervise public health." N.Y. Br. 21-22; *see also* NGA Br. 5-8. These databases are a better, more comprehensive version of the work States have done for decades, if not longer. *See* Pet. Br. 4-8. Collecting across-the-board expenditure information greatly increases transparency, provides real opportunities to reduce unnecessary spending, and benefits patients. *See, e.g.*, NAHDO Br. 21-27; CHLPI Br. 12-18; N.Y. Br. 9-22; AARP Br. 7-14. Liberty Mutual does not even attempt to show otherwise.[11] The Court should not lightly conclude that Congress intended ERISA as a roadblock to that "rare innovation that presents simultaneous opportunities to improve public health, reduce costs, and increase transparency." AHA Br. 16-17.[12]

Second, self-funded ERISA plans cover more than 60% of Americans who receive insurance through their employers and nearly 20% of all Vermonters. Pet. Br. 12; CHLPI Br. 20. Without their data, state

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[11] The Blue Cross Blue Shield of Massachusetts Foundation supports research using APCDs. *See* Press Release, Blue Cross Blue Shield of Massachusetts Found. (Jan. 8, 2013) (awards for projects using APCD), http://bluecrossmafoundation.org/press/blue-cross-blue-shield-massachusetts-foundation-awards-575000-policy-research-grants-advance; Blue Cross Blue Shield of Massachusetts Found., *Policy and Research Grants: 2015 Request for Proposals* 4, http://bluecrossfoundation.org/sites/default/files/download/grants/2015%20Policy%20Grant%20Guidelines_final.pdf.

[12] *See* Craig Jones et al., *Vermont's Community-Oriented All-Payer Medical Home Model Reduces Expenditures and Utilization While Delivering High-Quality Care*, Population Health Mgmt. (forthcoming) (evaluation of medical homes using VHCURES shows reduced expenditures and improved outcomes), http://online.liebertpub.com/doi/pdfplus/10.1089/pop.2015.0055.

databases would be less comprehensive, skewed toward an older and sicker demographic, and ultimately much less useful—they would "no longer provide an accurate portrait of the health of the general State population." CHLPI Br. 20-24; AHA Br. 18-20.

Third, as the United States explains, "data collected by the Vermont reporting requirements are integral to achieving the objectives of other federal statutory provisions." U.S. Br. 11. The United States, petitioner, and *amici* have all outlined ways in which the federal government supports and relies on comprehensive state databases. U.S. Br. 19-21; Pet. Br. 47-50; NAHDO Br. 30-36; N.Y. Br. 13-14. Liberty Mutual has no explanation for why Congress would authorize the federal government to provide Medicare claims data, if ERISA blocks States from collecting data from other payers. *See* Resp. Br. 49. It dismisses the grant funding that the federal government has provided for APCD development on the (irrelevant) basis that the government also provided grants for other purposes. *Id.* at 50 n.29. And Liberty Mutual does not dispute that States would need comprehensive data to "test and evaluate systems of all-payer payment reform," 42 U.S.C. § 1315a(b)(2)(B)(xi), but instead suggests creating a new federal program, unmentioned in the statute, to collect data from ERISA plans. Resp. Br. 50. The Court should not preempt state APCD laws when doing so would "frustrate the objectives of other important federal statutory provisions." U.S. Br. 19.

CONCLUSION

The decision below should be reversed.

Respectfully submitted,

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November 12, 2015

No. 14-181

IN THE

Supreme Court of the United States

ALFRED GOBEILLE, in his official capacity as chair of the Vermont Green Mountain Care Board,
Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,
Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

SUPPLEMENTAL BRIEF FOR RESPONDENT

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SUPPLEMENTAL BRIEF FOR RESPONDENT

As the Brief for the United States makes clear, further review of the decision below is unwarranted. The court of appeals' decision—which held that ERISA preempts Vermont legislation and implementing regulations that, as applied in this case, would have compelled reporting to the State data about claims paid under the terms of ERISA plans—does not directly conflict with any decision of this Court or any other court of appeals.[1] *See* U.S. Br. 18-21; *see also* Br. in Opp. 24-

[1] The United States does argue (Br. 11-17) that the court of appeals erred in holding the Vermont reporting requirements preempted by ERISA, but appears to base its disagreement, at least in part, on a supposed lack of *factual* support for the court of

29. Further, the decision below is the first court of appeals decision to address such a reporting regime; because States within other circuits have enacted similar legislation, it is unlikely to be the last. *See* U.S. Br. 23. As the United States correctly observes, "further percolation of the question presented among the courts of appeals is likely to prove helpful to the Court" by "furnishing the perspective of other courts of appeals on the legal issue" and by potentially furnishing the Court "with more information to assess the impact of similar reporting requirements on the administration of ERISA plans generally." *Id.* For those reasons, the petition for a writ of certiorari should be denied.[2]

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appeals' decision, and the United States acknowledges that "the decision below does not purport to rest on a significant expansion of ERISA preemption principles" (*id.* at 19; *see also id.* at 15-16). For the reasons discussed in Respondent's Brief in Opposition, however, the court of appeals' decision reflects a proper application of the ERISA preemption principles in this Court's decisions and is correct. Br. in Opp. 14-24.

[2] The United States incorrectly argues (U.S. Br. 9-11) that this Court has jurisdiction because petitioner Gobeille, the Chair of the Vermont Green Mountain Care Board, was supposedly an appropriate party to petition for certiorari in this case. The subpoena that Liberty Mutual seeks to enjoin in this case was issued not by petitioner, but by the Commissioner of the Vermont Department of Financial Regulation (the "Commissioner") pursuant to a Vermont statute (8 V.S.A. § 13) that continues to grant the Commissioner the authority to issue and enforce such subpoenas to this day. *See* Br. in Opp. 3a-6a (subpoena); *see also id.* at 2 n.1 (noting that the Vermont Department of Financial Regulation was formerly known as the Vermont Department of Banking, Insurance, Securities and Health Care Administration). Because the Commissioner continues to have the authority to enforce the subpoena at issue, the Commissioner's duties have not been transferred to petitioner, and automatic substitution under S. Ct. R. 35.3 has not occurred. Although the United States argues that petitioner is

Review should be denied for an additional reason: The United States has disclosed that the Secretary of Labor (the Secretary), "in aid of his authority to ensure compliance with ERISA's fiduciary standards and claims-processing rules," is "currently considering undertaking a rulemaking to require health plans to report more detailed information about the cost of benefits, utilization of medical services, and plan administration." U.S. Br. 3 n.1. Although the specifics of this potential rulemaking are unclear, as described by the United States the rulemaking under consideration by the Secretary could impose on ERISA plans reporting requirements of the same type at issue in this case—reporting on the use of medical services by participants in ERISA plans. The possibility that such a rulemaking may occur in the near future weighs against review of the court of appeals' decision.

First, the potential rulemaking raises the possibility that ERISA plans will soon be subject to federal reporting requirements that overlap with the Vermont reporting regime at issue. Under such circumstances, the Vermont regime would almost certainly be preempted. Even in the absence of a direct conflict, a decision by the Secretary to impose such reporting requirements on

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now "the state official who seeks to enforce the respondent's compliance with [the reporting] requirements with respect to the subpoena in this case," U.S. Br. 10, there is no support in the record for the proposition that petitioner can enforce a subpoena issued under Title 8. Even if petitioner is the state official who will enforce Vermont's reporting requirements in the future pursuant to his own subpoena power under Title 18 of the Vermont Statutes, U.S. Br. 10-11, that shows only that the petitioner had an interest that might have justified intervention in the court of appeals, not that petitioner was automatically substituted for the Commissioner.

ERISA plans would make clear that the state reporting requirements at issue here are not "generally applicable laws regulating areas where ERISA has nothing to say," *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 147-148 (2001) (internal quotation marks omitted), but instead implicate a core area of ERISA concern reserved for exclusive federal regulation and should thus be preempted. At a minimum, the United States' note suggests the federal regulatory background to the preemption issue raised by this case may be about to shift. Under these circumstances, the Court would benefit from waiting until any new federal reporting requirements with respect to ERISA plans are settled before addressing whether state reporting requirements like those at issue here are preempted by ERISA.

Second, the rulemaking envisioned by the Secretary undermines petitioner's argument that the preemption issue in this case is so important that it requires this Court's immediate review (even in the absence of a conflict among the circuits). If the Secretary does require ERISA plans to report "more detailed information" about health-care benefits that they deliver, States will have no need to obtain that same information from ERISA plans. States could request such data from the Secretary, rather than imposing reporting requirements directly on ERISA plans, and could thus avoid the preemption issues presented by this case.[3] Any rulemaking would be subject to notice and comment, and Vermont and other States seeking claims data from ERISA plans would be free to comment on the kinds of

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[3] As the United States notes, the federal Centers for Medicare and Medicaid Services already provide Medicare claims data to Vermont for use in its database. U.S. Br. 18 n.7.

information that should be subject to federal ERISA reporting requirements, including advocating for federal reporting of the same information Vermont currently seeks. Employers could also provide comments on the kinds of uniform reporting rules that should be developed to reduce administrative burdens and protect the confidentiality of plan participants. Whether the Secretary will impose federal reporting requirements, what the scope of those requirements will be, and how States will react to and use the federal reporting requirements when developing their own claims databases are all questions that should be resolved before this Court addresses the preemptive effect of ERISA on state reporting regimes like those at issue here.

Finally, the United States' explanation of the Secretary's authority for the potential rulemaking itself illustrates why the court of appeals properly concluded that ERISA preempts the Vermont reporting requirements at issue. The United States acknowledges (at 3 n.1) that the Secretary's potential rulemaking and imposition of reporting requirements would be done in aid of the Secretary's "authority to ensure compliance with ERISA's fiduciary standards." The United States' description of the potential rulemaking as in aid of ERISA's fiduciary standards thus confirms—contrary to petitioner's assertion that Vermont's reporting requirements are unrelated to ERISA's principal concerns and thus are not preempted[4]—that there is a relationship between a requirement that an ERISA plan report on the use of medical services by plan par-

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[4] *See, e.g.*, Pet. 20 ("Vermont's health care database ... is unrelated to ERISA's core concern with plan administrators' fiduciary responsibilities to beneficiaries.").

ticipants and the core concerns of ERISA. Because such reporting requirements have a clear "connection with" an ERISA plan, *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983), they fall within the realm of exclusive federal authority, and any attempt by the States to impose such requirements are preempted.

CONCLUSION

The petition for a writ of certiorari should be denied.

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In The
Supreme Court of the United States

ALFRED J. GOBEILLE, IN HIS OFFICIAL CAPACITY AS CHAIR OF THE VERMONT GREEN MOUNTAIN CARE BOARD,

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

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The Solicitor General agrees with petitioner and the *amici* States that this ERISA preemption case raises a question of "national importance." U.S. Br. 9. The Solicitor General also agrees that the Second Circuit had "no sound basis" for its holding that Vermont's all-payer claims database statute is preempted as applied to self-funded ERISA plans. *Id.* at 15. And the Solicitor General recognizes the value of all-payer claims databases, the unique role of the States in building these programs, and the federal government's own encouragement and support for state databases. These factors all demonstrate the need for this Court's immediate review.

The Solicitor General's caution and suggestion that the Court allow time for further percolation should not deter the Court from granting certiorari to review the Second Circuit's seriously flawed application of ERISA preemption. A wait-and-see approach harms the States' substantial interest in adopting health care policies that best serve the needs of their citizens. At least eleven States have similar databases in place and several more, including New York and Connecticut, are implementing these programs. Amicus Br. N.Y. et al. 1-2 & n.1. As health care costs continue to skyrocket and place enormous pressures on state budgets, the States have an urgent need to take advantage of the "great potential," U.S. Br. 21, offered by all-payer claims databases.

The Solicitor General squarely rejects Liberty Mutual's jurisdictional argument and offers little discussion of the benefits of delaying review. But the

States have much to lose if the Second Circuit's expansive view of ERISA preemption – which departs substantially from this Court's precedents – is left standing. The Court should grant the petition.

I. The Solicitor General agrees with Vermont and the *amici* States that this question of ERISA preemption has national importance and that the Second Circuit erred in holding Vermont's statute preempted.

A. As the Solicitor General explains, "the question presented . . . has substantial importance to the Nation's healthcare system." U.S. Br. 23. The "States are uniquely positioned to improve quality of care and to control costs through the collection and publication of claims data." *Id.* at 22. Indeed, the Solicitor General supports Vermont and the *amici* States on key points that confirm the importance of all-payer claims databases:

- The "development of state healthcare claims databases has great potential to improve healthcare outcomes nationally." U.S. Br. 21; *see* Pet. 26-31 (addressing potential of databases to reduce costs, improve quality of care, and promote transparency); Amicus Br. N.Y. et al. 4-7 (databases "help to promote efficient and effective health care").

- Contrary to Liberty Mutual's assertions (Opp. 30-31), these databases "will be

significantly less comprehensive and thus not as useful in developing health policy" absent data from self-insured ERISA plans. U.S. Br. 22; *see* Amicus Br. N.Y. et al. 7 (explaining that Second Circuit's ruling would "create significant and serious gaps" in claims data because self-funded plans cover "a large and distinctive subpopulation"); Pet. Reply 3-5.

- All-payer claims databases are critical for evaluating new health care models for payment and service delivery. *See* U.S. Br. 22 ("it is essential to the accuracy of some evaluations to be able to analyze state-level databases that include all payer claims"); Pet. 5-6 (Board "relies on the data for oversight and evaluation of health care payment and delivery system reforms").

- Because the federal government "recogniz[es] the importance of access to comprehensive claims data," it provides Medicare claims data to Vermont and other states. U.S. Br. 22 (citing 42 U.S.C. § 1395kk); *id.* at 17-18 n.7 (noting that CMS provides Medicare claims data to Vermont).

The Solicitor General's filing shows, as Vermont has argued, that the Second Circuit's ruling "treads on both state and *federal* interests." Pet. 15. Programs encouraged, supported, and funded by the federal government rely on comprehensive all-payer claims databases. U.S. Br. 9, 21-23. State interest in

creating databases also continues to grow. *See, e.g.*, APCD Council, *Model All-Payer Claims Database (APCD) Legislation*, at 2 (May 2015) ("an ever-growing number of states are implementing All-Payer Claims Databases (APCDs), aggregating claims and administrative data from public and private payers statewide").[1] This issue of "national importance," U.S. Br. 9, warrants review by this Court.

B. The Solicitor General agrees that Vermont's database statute and regulation are not preempted by ERISA and the "court of appeals was wrong" to conclude otherwise. U.S. Br. 17.

First, and crucially, the Solicitor General recognizes that "the Vermont reporting requirements" have "an entirely different focus" from ERISA's financial and actuarial reporting requirements. U.S. Br. 13; *see* 29 U.S.C. § 1023. Vermont's all-payer claims database is a tool for evaluating and improving health care outcomes and policies. *See* Vt. Stat. Ann. tit. 18, §§ 9401(a), 9410(a)(1). Vermont seeks de-identified claims data as part of its oversight of the health care system – a traditional state function. *See N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995) (Congress did not intend to "displace general health care regulation, which historically has been a matter of local concern."). The State is not regulating or seeking

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[1] Available at: http://apcdcouncil.org/sites/apcdcouncil.org/files/Model%20APCD%20Legislation_FINAL_0.pdf.

information about plan financing, governance, or the relationship between the plan and its members. The database statute thus has "nothing to do with ERISA's principal concerns with the soundness of plans" or the plans' "federal-law obligation to pay promised benefits." U.S. Br. 14-15; *see Cal. Div. Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 326-27 (1997) (ERISA reporting, disclosure, and fiduciary requirements adopted to protect against poor management by plan administrator); *see also* Pet. App. 38 (Straub, J., dissenting) (purpose of ERISA's reporting requirements is "wholly distinct" from Vermont's law).

Second, the Solicitor General agrees that the "mere fact that a state-law reporting obligation encompasses information about the operation of an ERISA plan does not suffice for preemption." U.S. Br. 14. Instead of starting with the presumption against preemption of state laws regulating health care, *see* Pet. App. 18 n.8, the panel majority below presumed instead that a state law involving "plan record-keeping, and filing with a third party" intrudes on a core area of ERISA concern. Pet. App. 23-24. The Solicitor General corrects this flawed view of ERISA preemption. *See* U.S. Br. 14-15.

Third, the Solicitor General, like the dissenting judge below, finds no basis in this record to hold that Vermont's law is preempted. U.S. Br. 15-16. The relevant inquiry is whether Vermont's law "interfere[s] with the way in which the plan is administered," and there is no showing "that the

requirements here have such an effect." *Id.* at 16-17. Regardless, Liberty Mutual's assertion, and the panel's unsubstantiated conclusion, that Vermont's law is burdensome lack factual support. *Id.* at 13, 16-17, 19.

II. The Solicitor General agrees that the Chair is the proper party to seek review in this Court.

The Solicitor General recognizes that the petition was filed by the proper party to defend Vermont's statute, the Chair of the Green Mountain Care Board. U.S. Br. 9-11. The original defendant in this case, the commissioner of a different state agency, no longer enforces the database statute and regulation. *See* Pet. App. 92-99; Pet. Reply App. 25-34. The permanent declaratory and injunctive relief that Liberty Mutual seeks, Pet. Reply App. 16-17, would now "run against the Chair." U.S. Br. 10. That suffices to show that the party substitution was appropriate. *See* Pet. Reply 9-13.

Although this Court could deem the petition to include a motion to substitute the Chair as a party, *see* U.S. Br. 11 n.6, no motion is required under Supreme Court Rule 35.3 or the analogous civil and appellate rules. *See* Fed. R. App. P. 43(c); Fed. R. Civ. P. 25(d). Even Liberty Mutual acknowledges the longstanding view that a transfer of "relevant enforcement responsibilities" between offices makes the transferee a successor in office under these rules.

Opp. 11 n.4 (citing Wright et al., *Federal Practice and Procedure* § 1960, at 715 & n.6 (3d ed. 1997)); *see* Pet. Reply 11 (citing cases); *see also Indep. U.S. Tanker Owners Comm. v. Lewis*, 690 F.2d 908, 910-11 n.1 (D.C. Cir. 1982) (recognizing substitution under Fed. R. Civ. P. 25(d) where authority was transferred from Secretary of Commerce to Secretary of Transportation). The Board Chair was automatically substituted as the defendant by operation of Fed. R. App. P. 43(c) on July 1, 2013, when the state law transferring authority to the Board took effect. 2013 Vt. Acts & Resolves, No. 79, sec. 40; *id.* sec. 53(h).

III. Given the States' pressing need to address health care costs, quality, and access, the Court should not wait for a decision from another circuit.

After acknowledging the Second Circuit's erroneous application of ERISA preemption and the "substantial importance" of the question presented, the Solicitor General nonetheless recommends "further percolation" for an undefined period of time. U.S. Br. 23. State governments cannot afford the luxury of "percolation." Health care costs continue to escalate at hyperinflationary rates while legislatures attempt to balance budgets and human services agencies strive to ensure adequate access to care. The Court should grant review and decide this important question now.

Although the Solicitor General does not see a "square conflict" here, U.S. Br. 20, his unambiguous conclusion that the Second Circuit was "wrong" in finding preemption, *id.* at 17, underscores the panel's significant misapplication of this Court's precedent. Moreover, the Solicitor General's brief does not address the lower court's failure to apply the presumption against preemption of state law, which the dissenting judge below described as "fl[ying] in the face of clear Supreme Court precedent." Pet. App. 33 (Straub, J., dissenting). And the Sixth Circuit pointedly agreed with Judge Straub that the panel majority's "literal approach to preemption" disregards "'the case law's focus on whether the *administration of benefits to beneficiaries* is impacted.'" *Self-Ins. Inst. of America, Inc. v. Snyder ("SIIA")*, 761 F.3d 631, 639 (6th Cir. 2014) (quoting Pet. App. 33 (Straub, J., dissenting)), *petition for cert. filed*, 83 U.S.L.W. 3560 (U.S. Dec. 18, 2014) (Nos. 14-741, 14A373). Even if *SIIA* does not directly conflict with the decision below, the Sixth Circuit's rejoinder to its sister circuit confirms that the panel majority departed substantially from the principles set forth in this Court's ERISA precedents. *See generally* Pet. 15-25. A direct conflict is not a prerequisite for reviewing a question of "substantial" and "national" importance, U.S. Br. 9, 23, especially where, as here, the lower court has misapplied this Court's holdings.

In any event, the Solicitor General's one-paragraph discussion of the benefits of percolation offers little reason for delaying review. *See* U.S. Br.

23. The brief does not point to any other pending cases that would serve as a better vehicle. The Solicitor General briefly suggests that "additional appellate decisions" may supply "more information to assess the impact" of similar laws on ERISA plans. *Id.* Yet in this case Liberty Mutual, on its own motion for summary judgment, was unable to produce any evidence that Vermont's database law burdened plan administration. Pet. App. 72-73 n.5. There is no reason to think that Liberty Mutual, a sophisticated litigant represented by experienced counsel, inadvertently neglected to supply relevant evidence on this point. Rather, the absence of evidence in the record below confirms that providing claims data to state databases has little or no impact on ERISA plans. *See* Pet. App. 43-44, 46 (Straub, J., dissenting); U.S. Br. 16.

In fact, there is little benefit to postponing review, while delay undermines the States' substantial interest in developing health care databases and using them to inform health care policy. At least sixteen States, including all three states in the Second Circuit, already have or are developing health care databases similar to Vermont's. Amicus Br. N.Y. et al. 1-2 & n.3.[2] These States *and the federal*

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[2] A current survey shows twelve states with all-payer claims databases in place and six states with databases in development, bringing the total to eighteen. APCD Council, *Interactive State Map*, http://apcdcouncil.org/state/map (last visited May 29, 2015).

government have invested substantial resources to create these programs. *See id.* at 3 (describing New York's $10 million investment and Connecticut's $6.5 million federal grant). The Solicitor General agrees with Vermont and the *amici* States that databases without data from self-insured ERISA plans will be "significantly less comprehensive and thus not as useful in developing health policy at both the state and national levels." U.S. Br. 22-23; *see* Amicus Br. N.Y. et al. 3 ("The usefulness of an all-payer claims database comes principally from its comprehensiveness."). States should not be forced to make do with incomplete data and lose the full value of their investments while waiting, perhaps for years, for another case to work its way through the system.

Indeed, evidence-based reform supported by all-payer claims databases is a vital tool in the national effort to contain health care costs while improving quality and access to care. States are rapidly developing claims databases because analysis of this information yields powerful insights. *See, e.g.*, Network for Excellence in Health Innovation, *All Payer Claims Databases: Unlocking the Potential*, at 1 (Dec. 2014) (all-payer claims databases "are now providing unprecedented research and policy opportunities for improving the health care delivery system").[3] As the Solicitor General's brief acknowledges, the federal government itself is funding "development and

[3] Available at: http://www.milbank.org/uploads/documents/reports/All-Payer-Claims-Databases-Unlocking-the-Potential.pdf.

testing of new healthcare payment and service-delivery models" that "rely on state data-collection efforts for evaluation." U.S. Br. 21. Building accurate, comprehensive databases, and using that data to guide policy, is work that needs to be done, and done as soon as possible. The Second Circuit's decision in this case is a roadblock to effective reform that only this Court can remove.

CONCLUSION

The petition for writ of certiorari should be granted.

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No. 14-181

In the Supreme Court of the United States

ALFRED GOBEILLE, IN HIS OFFICIAL CAPACITY AS CHAIR OF THE VERMONT GREEN MOUNTAIN CARE BOARD, PETITIONER

v.

LIBERTY MUTUAL INSURANCE COMPANY

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER

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QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.*, preempts, as applied to self-insured health benefit plans or their third-party administrators, a Vermont statute that requires healthcare payers to report claims and healthcare-services data to a state agency.

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In the Supreme Court of the United States

No. 14-181

ALFRED GOBEILLE, IN HIS OFFICIAL CAPACITY AS CHAIR OF THE VERMONT GREEN MOUNTAIN CARE BOARD, PETITIONER

v.

LIBERTY MUTUAL INSURANCE COMPANY

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER

INTEREST OF THE UNITED STATES

This case concerns whether the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, preempts a state law imposing certain reporting requirements on healthcare payers, including ERISA plans. The Secretary of Labor has primary authority for administering ERISA. 29 U.S.C. 1002(13), 1132-1135. In response to an invitation from the Court, the United States filed an amicus brief in this case at the petition stage.

STATUTORY AND REGULATORY PROVISIONS INVOLVED

The pertinent statutory and regulatory provisions are reproduced in the appendix to this brief. See App., *infra*, 1a-59a.

STATEMENT

1. The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, is designed to "protect * * * the interests of participants in employee benefit plans and their beneficiaries * * * by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. 1001(b). The statute governs both pension plans and "employee welfare benefit plan[s]," *i.e.*, plans that, "through the purchase of insurance or otherwise," provide medical, disability, unemployment, vacation, or certain other benefits. 29 U.S.C. 1002(1). ERISA requires every plan to be established and maintained pursuant to a written instrument and to have named fiduciaries who have authority to control and manage the administration of the plan and its assets. 29 U.S.C. 1102(a)(1), 1103(a). With specified exceptions, ERISA preempts "any and all State laws insofar as they * * * relate to any employee benefit plan." 29 U.S.C. 1144(a).

Plan administrators generally must file detailed financial and actuarial information with the Secretary of Labor (Secretary) and submit reports upon the occurrence of specific events, although the Secretary has exempted most welfare plans from the majority of those requirements. 29 U.S.C. 1021-1024; 29 C.F.R. Pt. 2520. In addition, the Secretary has authority to

investigate plans for ERISA violations by inspecting plan documents, administrative contracts, and claims records. 29 U.S.C. 1134. ERISA also authorizes the Secretary "to undertake research and surveys and in connection therewith to collect, compile, analyze and publish data, information, and statistics relating to employee benefit plans." 29 U.S.C. 1143(a)(1).

ERISA includes certain provisions governing "group health plan[s]," *i.e.*, ERISA welfare plans that provide medical benefits, 29 U.S.C. 1191b(a), that were originally enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, § 101(a), 110 Stat. 1939. See 29 U.S.C. 1181-1191c. In 2010, Congress enacted the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119, which imposes a number of new requirements on the group health-insurance market, such as a prohibition on charging different premiums based on health status. See § 1001, 124 Stat. 130; see also 42 U.S.C. 300gg *et seq.* In a section setting out "conforming amendments," ACA § 1563, 124 Stat. 264, 911 (capitalization and emphasis omitted), the ACA also amended ERISA to provide that those new provisions generally apply to group health plans and that, in the event of a conflict between those ACA provisions and the sections of ERISA addressing group health plans, the ACA provisions govern. See *id.* § 1563(e), 124 Stat. 270, 911 (29 U.S.C. 1185d). The new ACA provisions applicable to group health plans include reporting and disclosure requirements related to such matters as claims-payment policies, out-of-network coverage, data on enrollment and denied claims, financial information, and information on the existence of any quali-

ty initiatives or wellness programs under the plan. See 42 U.S.C. 300gg-15a (incorporating provisions of 42 U.S.C. 18031(e)(3)); 42 U.S.C. 300gg-17(a) and (b).

Those provisions of the ACA have not yet been implemented. The Department of Labor has informed this Office, however, that pursuant to the authority granted by ERISA and the ACA, and in consultation with the Department of Health and Human Services (HHS) and the Department of the Treasury, it is currently considering a rulemaking to require health plans to report more detailed information about various aspects of plan administration, such as enrollment, claims processing, and benefit offerings.

2. The Vermont Legislature has enacted a comprehensive health law designed to "[m]aintain and improve the quality of health care services offered to Vermonters," "[u]tilize planning, market, and other mechanisms that contain or reduce increases in the cost of delivering services," and "[e]ncourage regional and local participation in decisions about health care delivery, financing, and provider supply." Vt. Stat. Ann. tit. 18, § 9401(b)(1)-(3) (2012). One provision of the statute requires the Green Mountain Care Board (Board), a state agency, to develop and maintain a database of information about healthcare expenditures in the State and out-of-state healthcare expenditures involving Vermont residents. See *id.* § 9410 (Supp. 2014) (Database Statute). The database is designed to help "identify[] health care needs," "compar[e] costs between various treatment settings and approaches," "determin[e] the capacity and distribution of existing resources," and "provid[e] information to consumers and purchasers of health care." *Id.* § 9410(a)(1) (Supp. 2014).

The database must "reflect all health care utilization, costs, and resources" for medical services provided to Vermont residents or by Vermont facilities. Database Statute § 9410(b) (Supp. 2014). To that end, the Database Statute authorizes the Board to require "[h]ealth insurers, health care providers, health care facilities, and governmental agencies" to submit "reports, data, schedules, statistics, or other information." *Id.* § 9410(c)-(d) (Supp. 2014). The information may include "health insurance claims and enrollment information" and "any other information relating to health care costs, prices, quality, utilization, or resources." *Id.* § 9410(c)(1) and (3) (Supp. 2014). The law's definition of "[h]ealth insurer" includes any health-insurance company and, "to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities," Vt. Stat. Ann. tit. 18, § 9402(8) (2012), as well as any third-party administrator that a self-insured health plan employs to handle such functions as claims processing, bill review, and claims payments, Database Statute § 9410(j)(1)(A) and (B) (Supp. 2014).

The Database Statute provides that, "[t]o the extent allowed by HIPAA, the [collected] data shall be available as a resource for insurers, employers, providers, purchasers of health care, and State agencies to continuously review health care utilization, expenditures, and performance in Vermont." § 9410(h)(3)(B) (Supp. 2014); see *id.* § 9410(h)(3)(C) (Supp. 2014). It also requires the Board to establish "a consumer health care price and quality information system" to "empower individuals, including uninsured individuals, to make economically sound and medically appro-

priate decisions." *Id.* § 9410(a)(2)(A) (Supp. 2014). In addition, the statute directs that "[r]ecords of information * * * required by law to be held confidential[] shall be filed in a manner that does not disclose the identity of the protected person," *id.* § 9410(e) (Supp. 2014), requires the Board to "adopt a confidentiality code," *id.* § 9410(f) (Supp. 2014), and prohibits the disclosure of "any data that contains direct personal identifiers," *id.* § 9410(h)(3)(D) (Supp. 2014). Knowing violations of the statute or implementing rules promulgated by the Board are punished through financial penalties. *Id.* § 9410(g) (Supp. 2014).

The Board's predecessor promulgated a regulation implementing the statute's requirements with respect to healthcare payers. See Reg. H-2008-01, 21-040-021 Vt. Code R. (2008) (Database Regulation). (The Board also administers a separate database for hospital-discharge data that is not at issue here. See Pet. Br. 7 & n.6.) The Database Regulation provides that "Health Insurers shall regularly submit medical claims data, pharmacy claims data, member eligibility data, provider data, and other information relating to health care provided to Vermont residents and health care provided by Vermont health care providers and facilities." § 4(D). The claims data comprise only information about "non-denied adjudicated [medical and pharmacy] claims." *Id.* § 3(Ac); see *id.* § 3(Ak); see also *id.* § 5(A)(8). The data include information about "member demographics, provider information, charge/payment information, and clinical diagnosis and procedure codes." *Id.* § 3(Ac). The regulation establishes requirements for how the data must be formatted, when it must be submitted, and under what circumstances different types of data will be released

to the public or to specific requestors, such as researchers. *Id.* §§ 5-8. It exempts health insurers with fewer than 200 enrolled or covered members in Vermont from the reporting requirements, although they may voluntarily report. *Id.* § 3(Ab) and (As).

The Board uses the claims database in fulfilling its statutory responsibilities, such as approving insurance rates and reviewing hospital budgets. See Pet. Br. 15-16, 33-35. In 2014, HHS issued a grant to the Board to expand its use of the database in connection with Vermont's rate-review authority under the ACA. *Id.* at 49-50 & n.29; see 42 U.S.C. 300gg-94(c)(1)(C). In addition, HHS supplies Medicare data to the Board, see 42 U.S.C. 1395kk(e), and has authorized the Board to include Medicaid data, see Pet. Br. 10. Over a dozen other States have enacted legislation to build similar databases. See N.Y. et al. Cert. Amicus Br. 1 & n.3.

3. Respondent is the named fiduciary and administrator of an ERISA self-insured health plan for its employees. Pet. App. 7. A self-insured plan is one in which the plan sponsor pays claims out of its own assets or from a trust, rather than contracting with an insurance company to pay claims under an insurance policy. Because only 137 persons covered by respondent's health plan live in Vermont, respondent is not itself required to report healthcare-expenditure information to the Board. *Id.* at 7-8. But respondent's plan is administered by a third-party administrator—Blue Cross Blue Shield of Massachusetts, Inc. (Blue Cross)—that qualifies as a mandatory reporter under the Database Regulation because it administers claims for thousands of individuals in Vermont. *Id.* at 8; see J.A. 205. In August 2011, the Board's predeces-

sor issued a subpoena to Blue Cross, seeking eligibility information and medical- and pharmacy-claims files for Vermont residents covered by respondent's plan, which had not been reported as required by the Database Statute and Regulation. J.A. 30-33. Respondent, believing that the request was preempted by ERISA, instructed Blue Cross not to comply with the subpoena. Pet. App. 9.

Respondent then filed suit in the United States District Court for the District of Vermont against the Board's predecessor. J.A. 12-28. Respondent sought a declaratory judgment that the Database Statute and Regulation "are preempted by ERISA to the extent they require the reporting, production, or disclosure of any confidential health care information or medical records or data relating to [respondent's health] [p]lan or its participants and beneficiaries." J.A. 27. Respondent also sought to enjoin the Commissioner "from attempting to obtain, from [Blue Cross] or any other source, any medical records or data relating to the [p]lan or its participants and beneficiaries." J.A. 28.

The district court dismissed the complaint, holding that the Vermont reporting requirements are not preempted by ERISA. Pet. App. 48-80. The court explained that although "[c]ompliance with the reporting requirements * * * may have some indirect effect on health benefit plans," the possible "effect is so peripheral that the regulation cannot be considered an attempt to interfere with the administration or structure of a welfare benefit plan." *Id.* at 78. The court emphasized that respondent had "not submitted any information about any actual burden suffered by

itself or [Blue Cross] in producing this information." *Id.* at 73 n.5.

4. The court of appeals reversed, holding that ERISA preempts the Vermont reporting requirements. Pet. App. 1-30. The court explained that under this Court's interpretation of ERISA's preemption provision, 29 U.S.C. 1144(a), "a state law is preempted if 'it [1] has a connection with or [2] reference to [an ERISA] plan.'" Pet. App. 14 (brackets in original) (quoting *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)). The court concluded that "the reporting requirements of the Vermont statute and regulation have a 'connection with' ERISA plans (though no 'reference to' them)" because "'reporting' is a core ERISA function shielded from potentially inconsistent and burdensome state regulation." *Id.* at 23. The court noted that Vermont could change the requirements at any time, *id.* at 27, and it postulated that if respondent were subject to "one of several or a score of uncoordinated state reporting regimes," the burden would be "obviously intolerable," *id.* at 25.

Judge Straub dissented in relevant part. Pet. App. 30-47. "Many state laws," he wrote, "may have an impact on the administration of an ERISA plan—for example, a work-place safety law, a prevailing wage law, or a law that requires companies to report employment data." *Id.* at 42. Although "[s]uch laws may impose additional costs," he concluded, "none of these laws impact *how benefits are administered to beneficiaries* and, therefore, they are not preempted by ERISA." *Ibid.* Judge Straub also found that "on the record before [the court,]" no basis existed to conclude that the Vermont reporting requirements would "hin-

der the national administration of employment benefit plans in any way." *Id.* at 44; see *id.* at 41-42.

SUMMARY OF ARGUMENT

ERISA does not preempt the Vermont reporting requirements.

A. Under this Court's precedents construing ERISA's preemption provision, 29 U.S.C. 1144(a), the Vermont reporting requirements do not "relate to" ERISA plans because they have neither a "reference to" nor a "connection with" such plans. *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 147 (2001) (citation omitted). As the court of appeals acknowledged, the requirements do not have a "reference to" ERISA plans because they operate on many healthcare payers, not only on ERISA plans, and the existence of an ERISA plan is not logically necessary to their operation. Pet. App. 23 n.9 (citations omitted). Preemption therefore turns on whether the requirements have a forbidden "connection with" ERISA plans. Although this Court has not defined that concept with great precision, it has evaluated the preemption question by "look[ing] both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive" and "to the nature of the effect of the state law on ERISA plans." *Egelhoff*, 532 U.S. at 147 (citations and internal quotation marks omitted). Under that approach, the requirements are not preempted.

1. The Database Statute and ERISA serve different purposes. ERISA governs the design and administration of employee benefit plans, including vesting requirements, health-benefit mandates, fiduciary duties, and remedies for breach. Its reporting and disclosure requirements further those purposes. The

Database Statute, in contrast, is designed to improve the quality, utilization, and cost of healthcare in Vermont by providing consumers, government officials, and researchers with comprehensive data about the healthcare-delivery system. Although those data are reflected in claims paid by various entities, including ERISA plans, the focus of the Vermont statute has nothing to do with the claims-payment process. That is why Vermont does not seek information on denied claims.

Because the Vermont reporting requirements operate in the traditional state sphere of health and safety, while ERISA is principally concerned with the distinct subject of ensuring that plans provide covered benefits, the reporting requirements are entitled to a presumption of validity under Section 1144(a). As this Court has cautioned, it would be "unsettling" to conclude that ERISA squelches an entire area of state regulation about which ERISA itself says little. *California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A.*, 519 U.S. 316, 330 (1997) (citation omitted). That discomfiting result would be particularly harmful here, because the data collected by the Vermont reporting requirements are integral to achieving the objectives of other federal statutory provisions.

2. The Vermont reporting requirements do not exert impermissible effects on the design or administration of ERISA plans. ERISA generally preempts those laws that prescribe binding rules for "a central matter of plan administration," such as "the payment of benefits," *Egelhoff*, 532 U.S. at 148, but it does not guarantee "cost uniformity" among different States where a plan might operate, *New York State Confer-*

ence of Blue Cross & Blue Shield Plans v. *Travelers Ins. Co.*, 514 U.S. 645, 662 (1995). The Vermont reporting requirements do not impose binding obligations with respect to any core matter of plan administration, such as the vesting of benefits, claims processing, or the designation of beneficiaries. Respondent's contrary argument essentially rests on the view that all reporting of information acquired or generated during the administration of a plan qualifies as a central matter of plan administration. But that argument conflicts with this Court's prior decisions and, taken to its logical conclusion, would sweep away virtually all state-law reporting requirements incident to laws of general applicability. And although this Court has suggested in dicta that a law imposing costs that are so acute as to effectively dictate how a plan is designed or administered would be preempted, no such extreme economic effects have been established here.

B. Some Justices have suggested in separate opinions that this Court should clarify its ERISA preemption jurisprudence by holding that Section 1144(a) merely calls for the application of ordinary principles of field and conflict preemption. Under those principles, the Vermont reporting requirements are not preempted. The requirements do not invade the exclusive federal field of the design and administration of ERISA plans. Nor do they conflict with any specific provision of ERISA or with Section 1144(a)'s basic objective to establish a uniform body of employee-benefits law.

ARGUMENT

THE VERMONT REPORTING REQUIREMENTS ARE NOT PREEMPTED BY ERISA

A. The Vermont Reporting Requirements Do Not Fall Within ERISA's Express Preemption Provision

Section 1144(a) of ERISA expressly preempts state statutes and regulations that "relate to" an ERISA plan, except for "any law * * * which regulates insurance, banking, or securities," "any generally applicable criminal law," and other specified categories of state laws. 29 U.S.C. 1144(a), (b)(2)(A), (4), and (c)(1). Under this Court's precedents construing that provision, "[a] law 'relates to' an employee benefit plan * * * if it has a connection with or reference to such a plan." *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983); see, *e.g.*, *Egelhoff* v. *Eglelhoff*, 532 U.S. 141, 147 (2001); *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 656 (1995) (*Travelers*).

The court of appeals correctly concluded (and respondent has not contested) that the Vermont reporting requirements do not have a "reference to" ERISA plans. Pet. App. 23 n.9 (citations omitted). A law has a "reference to" ERISA plans if it "acts immediately and exclusively upon ERISA plans" or "the existence of ERISA plans is essential to the law's operation." *California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A.*, 519 U.S. 316, 325-326 (1997) (*Dillingham*). The Vermont reporting requirements apply to many healthcare payers, not only to ERISA plans. Database Statute § 9410(c) (Supp. 2014); see Database Regulation §§ 3(X), 4. And they could function independently of the existence of ERISA plans, though excluding ERISA plans would

render Vermont's database far less comprehensive and thus less useful. For these reasons, the reporting requirements do not resemble the state laws that this Court has held to have a specific "reference to" ERISA plans. Those laws have targeted ERISA plans with specificity. See *District of Columbia* v. *Greater Wash. Bd. of Trade*, 506 U.S. 125, 128, 129-133 (1992) (workers' compensation law that required employee benefits "set by reference to [ERISA] plans") (citation omitted); *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 135-136, 140 (1990) (common-law claim for wrongful discharge to prevent attainment of ERISA benefits); *Mackey* v. *Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 828 & n.2, 829-830 (1988) (exemption from garnishment statute for ERISA plans).

Accordingly, whether Section 1144(a) preempts the Vermont reporting requirements turns on whether the requirements have an impermissible "connection with" ERISA plans. This Court has acknowledged that the phrase "'connection with' is scarcely more restrictive than 'relate to'" and has therefore "cautioned against an uncritical literalism that would make pre-emption turn on infinite connections." *Egelhoff*, 532 U.S. at 147 (citation and internal quotation marks omitted). To avoid such an expansive breadth, the Court has "look[ed] both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive" and "to the nature of the effect of the state law on ERISA plans." *Ibid.* (citations and internal quotation marks omitted); see *Travelers*, 514 U.S. at 655-656.

Much like ordinary field preemption, the first inquiry essentially asks whether the challenged state law is directed at "an area of core ERISA concern":

the design and administration of employer-sponsored pension and welfare plans. *Egelhoff*, 532 U.S. at 147; see, *e.g.*, *Dillingham*, 519 U.S. at 330-331. The second inquiry asks whether, even if the law is not overtly directed at that field, its application would frustrate the purpose of ERISA's preemption provision "to ensure that plans and plan sponsors [are] subject to a uniform body of benefits law," *Ingersoll-Rand*, 498 U.S. at 142, by prescribing binding rules for the design or administration of ERISA plans. See *Egelhoff*, 532 U.S. at 148-149. In this case, the answer to each inquiry is no.

1. The Vermont reporting requirements serve objectives distinct from the basic purposes of ERISA

The Vermont reporting requirements operate in an area of traditional state regulation and bear only an attenuated relation to the purposes of ERISA. As such, they are entitled to a presumption of non-preemption under Section 1144(a)—a presumption fortified by the requirements' important role in achieving the goals of other federal legislation.

a. As discussed above, ERISA imposes a number of reporting requirements on plans, such as the submission of financial and actuarial information to the Secretary. See pp. 2-3, *supra*. Those requirements serve ERISA's basic purposes: to prevent the "mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds," *Dillingham*, 519 U.S. at 326-327 (quoting *Massachusetts* v. *Morash*, 490 U.S. 107, 115 (1989)), by enforcing "fiduciary standards on persons whose actions affect the amount of benefits * * * plan participants will receive," *John Hancock Mut. Life Ins. Co.* v. *Harris Trust &*

Sav. Bank, 510 U.S. 86, 96 (1993). See 29 U.S.C. 1001(b). Any state-law reporting requirements for the same purposes would raise a substantial preemption question. See *Standard Oil Co.* v. *Agsalud*, 633 F.2d 760, 763-766 (9th Cir. 1980) (holding preempted Hawaii reporting requirements incident to law requiring employers to provide prepaid health plan), summarily aff'd, 454 U.S. 801 (1981); see also *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 12-13 & n.7 (1987). That is because such requirements would effectively invade the field exclusively governed by ERISA and alter the approach that Congress adopted to ensure that plans are administered according to appropriate legal requirements.

The Vermont reporting requirements, however, have a different focus. The requirements are designed to populate a state database to be used to achieve a variety of general healthcare-related goals, including identifying the State's healthcare needs, enhancing resource utilization, comparing treatment costs and approaches, improving patient outcomes, and "mak[ing] available to consumers transparent health care price information, quality information, and such other information as * * * is necessary to empower individuals, including uninsured individuals, to make economically sound and medically appropriate decisions." Database Statute § 9410(a)(1) and (2)(A) (Supp. 2014). The Vermont reporting requirements, in other words, focus on the quality, cost, and transparency of medical treatment in the State. Those goals are part of an overall statutory scheme intended to "[m]aintain and improve the quality of health care services offered to Vermonters" and achieve other ends. Vt. Stat. Ann. tit. 18, § 9401(b) (2012).

That purpose is "quite remote from the areas with which ERISA is expressly concerned." *Dillingham*, 519 U.S. at 330; see 29 U.S.C. 1001(a) and (b). The purpose of Vermont's data collection is not to ensure that ERISA plans are sufficiently funded, pay benefits covered under the plan or required by federal law, or are administered in accordance with fiduciary standards. Indeed, the Database Regulation does not even seek information about all claims submitted by participants in ERISA welfare plans, but only about claims that are *paid*. See § 3(Ac) and (Ak); see also *id.* § 5(A)(8). That is because the focus of the regulation is not the claims processes of employee benefit plans, but rather healthcare expenditures, utilization, and cost. Vermont thus does not collect information about claims that are denied by ERISA plan administrators—a matter of central importance to ensuring that ERISA plans are being administered in accordance with their terms and with statutory requirements, but of relatively little importance to evaluating how healthcare dollars are spent in Vermont.

The Vermont reporting requirements, moreover, operate in an area squarely within the "historic police powers of the State": "the regulation of matters of health and safety," *De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 (1997). Although state collection and analysis of healthcare data is a relatively recent phenomenon, the basic objectives of the data analysis—improving healthcare quality, reducing healthcare costs, and helping Vermonters make informed medical decisions—reflect the long-standing interest of States in promoting the health of their citizens, including through information-collection efforts. See Pet. Br. 4-7, 32-34. And precisely be-

cause ERISA does not focus on analyzing general data about medical treatment across payers, ERISA does not establish a federal scheme for collecting and aggregating a broad set of data about medical treatment or provide any alternative mechanism by which state and local governments can do so. Cf. *Pegram* v. *Herdrich*, 530 U.S. 211, 214, 237 (2000) (explaining that medical-treatment decisions are not ERISA fiduciary acts despite their close relationship to decisions about what a health plan covers).

b. Because there exists little overlap between the objectives of ERISA and the objectives of the Vermont scheme, and because the Vermont scheme operates in an area of traditional state regulation, the reporting requirements are entitled to "the presumption that ERISA did not intend to supplant [them]." *Dillingham*, 519 U.S. at 331-332. As this Court has explained, "[a] reading of [Section 1144(a)] resulting in the pre-emption of traditionally state-regulated substantive law in those areas where ERISA has nothing to say would be 'unsettling.'" *Id.* at 330 (quoting *Travelers*, 514 U.S. at 665). Congress does not typically enact legislation in one substantive field with the intention to "squelch * * * state efforts" in a distinct sphere that has historically been regulated at the state and local levels and that the federal statute does not address. *Travelers*, 514 U.S. at 665. That is especially true "in the field of health care," where "there is no ERISA preemption without [a] clear manifestation of congressional purpose." *Pegram*, 530 U.S. at 237 (citing *Travelers*, 514 U.S. at 654-655).

Applying preemption so broadly would be particularly troublesome here because it would create a vacuum in a critically important area for the future of

healthcare. If reporting requirements like Vermont's were held invalid, States would be foreclosed from collecting information from employer-sponsored plans that are self-insured (except on a voluntary basis),* despite the fact that over a dozen States have determined that such informational efforts can improve their citizens' healthcare, lower costs, and enhance consumer choice. Pet. App. 7. That would create a significant gap; one study estimated that in 2011, 58.5% of workers were covered by self-insured health plans. Paul Fronstin, *Self-Insured Health Plans: State Variation and Recent Trends by Firm Size*, Emp. Benefit Res. Inst. Notes, Nov. 2012, at 2. Respondent has pointed to no evidence that Congress intended ERISA to thwart States' analytical initiatives. Particularly given that "nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation" by the States, *Travelers*, 514 U.S. at 661, this Court should be extremely reluctant to read such a broad preemptive scope into Section 1144(a).

c. There is another reason for caution before holding that the Vermont reporting requirements are preempted: Such a ruling would frustrate the objectives of other important federal statutory provisions.

In construing Section 1144(a), this Court has carefully attended to the objectives of other federal statutes, particularly in light of Section 1144(d), which provides that "[n]othing in this subchapter shall be construed to alter, amend, modify, invalidate, impair,

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* The court of appeals had no occasion to address whether its preemption holding applies to companies that insure ERISA plans, in light of Section 1144(b)(2)'s exemption from preemption for insurance regulation.

or supersede any law of the United States." Thus, for example, in *Travelers*, *supra*, the Court held a New York statute non-preempted in part because a federal statute subsequently enacted by the same Congress that enacted ERISA was "simply incompatible with pre-emption" of the state law. 514 U.S. at 666-667; see also *id.* at 667 n.6. Similarly, in *Shaw*, *supra*, the Court held that a New York law was not preempted "to the extent that the [law] provides a means of enforcing Title VII's commands." 463 U.S. at 102. The Court explained that the contrary view "would frustrate the goal of encouraging joint state/federal enforcement of Title VII." *Ibid.*

Here, provisions of the ACA rely on or encourage state data-collection efforts similar to Vermont's. Section 3021(a) of the ACA established the Center for Medicare and Medicaid Innovation (CMMI). See 124 Stat. 389 (42 U.S.C. 1315a). CMMI's charge is "to test innovative payment and service delivery models" that reduce costs "while preserving or enhancing the quality of care." 42 U.S.C. 1315a(a)(1). The ACA encourages CMMI to evaluate a variety of models, see 42 U.S.C. 1315a(b)(2)(B), including by "[a]llowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State," 42 U.S.C. 1315a(b)(2)(B)(xi). The ACA requires each model that CMMI tests to be evaluated by analyzing "the quality of care furnished under the model" and "the changes in spending under [Medicare, Medicaid and the Children's Health Insurance Program (CHIP)] by reason of the model." 42 U.S.C. 1315a(b)(4). In part because models may shift costs among different payers or have health effects that are not reflected in the Medicare, Medicaid, and CHIP

databases, access to comprehensive state-level databases is important for evaluating models. Accordingly, holding that initiatives like Vermont's are invalid would impede CMMI's statutory mission.

Congress also expressly recognized the importance of efforts to collect and analyze healthcare data in Section 10332 of the ACA. 124 Stat. 968 (42 U.S.C. 1395kk(e)). That provision requires the Secretary of HHS to make Medicare data available to entities that use claims data "to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use." 42 U.S.C. 1395kk(e)(2)(A). It is unlikely that Congress would have encouraged the development of such analytical efforts by making Medicare data available if it believed that States were prohibited by ERISA from obtaining data from other healthcare payers.

As discussed above (see pp. 3-4, *supra*), the ACA established new reporting requirements that apply to group health plans and insurance companies. 42 U.S.C. 300gg-15a, 300gg-17; see 29 U.S.C. 1185d(a). Respondent has not suggested that these new reporting requirements expand the scope of ERISA preemption in a way that is relevant to this case. Any such argument would conflict with the express terms of the ACA, which provides that "[n]othing in [ACA Title I, which includes the relevant provisions,] shall be construed to preempt any State law that does not prevent the application of the provisions of [ACA Title I]," 42 U.S.C. 18041(d). It would also conflict with ERISA itself. See 29 U.S.C. 1191(a)(2) ("Nothing in this part [29 U.S.C. 1181-1191c] shall be construed to affect or modify the provisions of section 1144 of [ERISA] with respect to group health plans."); see also 42 U.S.C.

300gg-23(a)(2). And in any event, those ACA reporting requirements focus on *plans* as such, seeking information on such matters as claims-payment policies, cost sharing for out-of-network coverage, enrollment figures, and whether certain types of benefits are being included in healthcare plans. 42 U.S.C. 300gg-15a (incorporating provisions of 42 U.S.C. 18031(e)(3)); 42 U.S.C. 300gg-17(a). They therefore would not fill the void left by invalidating state-level efforts to compile databases of healthcare-expenditure information across the board.

2. The Vermont reporting requirements do not exert an impermissible effect on the design or administration of ERISA plans

Because the Vermont reporting requirements operate in an area of traditional state regulation that is remote from the basic purposes of ERISA, they are entitled to a presumption against preemption under Section 1144(a). *Dillingham*, 519 U.S. at 330-332. That presumption could be overcome if the Vermont scheme, though not overtly directed at ERISA plans, nevertheless operated to prescribe binding rules for the design or administration of ERISA plans or exerted such powerful economic effects as to practically bind plan administrators to a particular course of conduct. But neither type of forbidden effect has been demonstrated here.

a. The purpose of ERISA's preemption provision is "to ensure that plans and plan sponsors [are] subject to a uniform body of benefits law" so that they are not required to "tailor[] * * * plans and employer conduct to the peculiarities of the law of each jurisdiction." *Ingersoll-Rand*, 498 U.S. at 142. That animating purpose "reflect[s] recognition of the administra-

tive realities of employee benefit plans": If multi-state plans were governed by different legal rules for core administrative functions, it "would produce considerable inefficiencies, which the employer might choose to offset by lowering benefit levels." *Fort Halifax*, 482 U.S. at 9-10.

For that reason, this Court has held that state laws "relate to" ERISA plans under Section 1144(a) if they "bind[] ERISA plan administrators to a particular choice of rules" for "a central matter of plan administration." *Egelhoff*, 532 U.S. at 147-148. For example, this Court has held that laws "relate to" ERISA plans when they designate beneficiaries of ERISA plans, *id.* at 143; "forbid[] a method of calculating pension benefits that federal law permits," *De Buono*, 520 U.S. at 814-815 (citing *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981)); or "require[] employers to provide certain benefits," *id.* at 815 (citing *Shaw, supra*, and *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724 (1985)).

Conversely, this Court has held that laws of general applicability that merely influence the choices made by ERISA sponsors or fiduciaries, but do not prescribe binding rules governing plan design or administration, are not preempted. See *Dillingham*, 519 U.S. at 329; *Travelers*, 514 U.S. at 657, 660, 664. If such laws were preempted, this Court has explained, the courts would "scarcely see the end of ERISA's pre-emptive reach, and the words 'relate to' would limit nothing." *Dillingham*, 519 U.S. at 329. The Court accordingly has sustained laws that "increase[] [the] costs of providing certain benefits, and thereby potentially affect[] the choices made by ERISA plans," *ibid.*, or that exert only an "indirect economic

influence" by making certain plan-administration choices more economically attractive, *Travelers*, 514 U.S. at 659. ERISA thus does not guarantee "cost uniformity" among States where a plan might operate. *Id.* at 662. After all, ordinary tax, wage, property, and health laws can vary from State to State and entail substantial administrative costs.

b. The Vermont reporting requirements do not exert an impermissible effect on ERISA plans because they do not prescribe binding rules for a central matter of plan administration. The reporting provisions do not dictate features of ERISA plans—vesting requirements, benefit levels, and so forth—nor do they impose rules on plan administrators for how claims should be processed and paid. See Pet. App. 72. They do not enhance or alter plan administrators' fiduciary duties or supplement ERISA's remedial scheme. See *Aetna Health Inc.* v. *Davila*, 542 U.S. 200, 214-215 (2004). The Vermont scheme does not, in other words, dictate how a plan must be administered. It therefore differs fundamentally from, for example, state-law rules governing beneficiary designations, which, if sustained, would demand that a fiduciary maintain familiarity with every relevant State's laws just to complete the basic functions of plan administration. Cf. *Egelhoff*, *supra*.

The court of appeals rested its contrary holding on the notion that *all* "reporting"—which the court defined as "plan record-keeping[] and filing with a third-party"—is "a core ERISA function." Pet. App. 23-24. Based on that premise, the court held that any state law that imposes a reporting obligation on an ERISA plan that is more than "slight" is preempted. *Ibid.* (citing *Shaw*, 463 U.S. at 98).

That conclusion was erroneous, even accepting the court of appeals' belief that the burden here is more than "slight" (but see pp. 28-29, *infra*). ERISA imposes reporting and disclosure obligations that further the regulation of the design and administration of employee benefit plans. Those obligations are integral to achieving ERISA's purposes, because they enable the Department of Labor and plan participants to ensure that the plan is being administered properly. But that does not mean that all reporting incident to state laws of general applicability that operate in disparate fields—taxes, property, wages—qualify as "core ERISA function[s]." And while decisions of this Court and the legislative history of ERISA identify "reporting" and "disclosure" as a central ERISA subject matter, those brief general statements, read in context, are best understood to refer to reporting ancillary to the areas that ERISA governs, not to any reporting obligation that might be imposed on an ERISA plan incident to enforcing an otherwise applicable state law. *E.g.*, *Dillingham*, 519 U.S. at 330 (quoting *Travelers*, 514 U.S. at 661); see, *e.g.*, S. Rep. No. 127, 93d Cong., 1st Sess. 35 (1973).

Any other reading would be untenable in light of the many types of general state laws to which ERISA plans are subject and would conflict with the Court's holdings in other cases that state laws containing reporting or record-keeping requirements are not preempted. In *De Buono*, for example, this Court held that a gross-receipts tax on patient services provided by a hospital operated by an ERISA plan was not preempted, see 520 U.S. at 809-810, 816, even though the administration of the tax required the filing of quarterly reports, see U.S. Amicus Br. at 2-3,

De Buono, *supra* (No. 95-1594). And in *Dillingham*, the Court held that California's prevailing-wage law was not preempted as applied to apprenticeship programs established as ERISA plans. See 519 U.S. at 319. Prevailing-wage laws typically require employers to keep records of the wages paid to employees and make them available for review by state authorities. See, *e.g.*, Cal. Lab. Code § 1776 (West 1989) (prevailing-wage law in *Dillingham*); see also, *e.g.*, *Keystone Chapter, Associated Builders & Contractors, Inc.* v. *Foley*, 37 F.3d 945, 962-963 (3d Cir. 1994), cert. denied, 514 U.S. 1032 (1995). And as petitioner points out (Pet. Br. 41), "ERISA contemplates that plans may offer * * * day care centers, training programs, and legal services"—activities that undoubtedly may be subject to state regulation and reporting requirements. 29 U.S.C. 1002(1). The court of appeals thus erred in concluding that any state-law reporting obligation that is more than "slight" is preempted.

For its part, respondent distinguishes (Br. in Opp. 26) other generally applicable state-law reporting obligations imposed on ERISA plans on the ground that the Vermont law "requires the reporting of information about core ERISA activities: the payment of claims under the plan." Cf. Pet. App. 29 n.13. Respondent essentially contends that all reporting that involves information acquired or generated during the administration of a plan qualifies as a core matter of plan administration.

That cannot be the test. Many generally applicable reporting requirements that apply to ERISA plans might seek for tax or other purposes information acquired or generated in the course of administering the plan—such as information about claims payments,

pension disbursements, employer contributions, or assets held in trust. An ERISA plan, after all, is not likely to have much information about matters not related to the administration of the plan. The gross-receipts reporting in *De Buono*, for example, concerned the amount of money that the plan was taking in through the medical centers that the plan was operating. The logical consequence of respondent's argument, therefore, is that almost no state-law reporting obligation would survive preemption, even those incident to otherwise valid laws of general applicability. Such a broad rule of preemption would conflict with this Court's reluctance to invalidate state laws that operate in areas to which ERISA does not speak and would reflect an unrealistic view of Congress's intent when it made reporting and disclosure in areas regulated by ERISA an exclusively federal concern.

c. This Court has suggested in dicta that "there might be a state law whose economic effects, intentionally or otherwise, were so acute as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and such a state law might indeed be pre-empted." *De Buono*, 520 U.S. at 816 n.16 (quoting *Travelers*, 514 U.S. at 668) (internal quotation marks omitted). It is therefore conceivable that a state-law reporting obligation that does not impose binding legal requirements on the design or administration of ERISA plans could be so costly as to be preempted. And in considering whether such an extreme economic effect exists, it is appropriate to consider the effect of a potential patchwork of state laws imposing different requirements. See *Egelhoff*, 532 U.S. at 149-150.

But in the posture of this case, no sound basis exists to conclude that the Vermont reporting requirements burden ERISA plans in a qualitatively different or more substantial way than "myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate." *Travelers*, 514 U.S. at 668. Indeed, there is no reason to conclude that the reporting requirements impose anything more than a de minimis financial burden, because respondent made no effort to quantify those costs in its filings below. As the district court explained after reviewing respondent's summary-judgment submissions, "[t]here is no evidence that the law * * * creates an economic effect so acute as to dictate certain administrative choices." Pet. App. 72.

The court of appeals nevertheless stated that "the reporting mandated by the Vermont statute and regulation is burdensome, time-consuming, and risky," particularly when considered "as one of several or a score of uncoordinated state reporting regimes." Pet. App. 25. Respondent contends (Br. in Opp. 20) that the court of appeals' view "reflects a common sense assessment of the administrative realities of ERISA plans."

The supposition that Vermont's requirements impose a substantial burden, however, is not obvious, or even particularly plausible, without any factual support. The Database Regulation essentially requires Blue Cross to take information generated in the ordinary course of its claims-payment operations and report that information in a prescribed format to the Board. Respondent has not suggested, let alone established, that Blue Cross has changed any aspect of its administration of the claims process because of

that reporting obligation. While organizing and formatting the data requires some administrative resources, it is implausible to assume that the additional cost would meaningfully alter the claims-payment process or any other aspect of the plan's administration. Indeed, Blue Cross presumably already has such procedures in place, given that it reports data to the Board for over 7000 individuals, see J.A. 205.

If the cost of compliance were in fact so significant as to alter Blue Cross's administration of claims, respondent could have submitted a declaration quantifying, or at least estimating, the burden, and explaining ways in which the reporting obligation has changed how its plan operates. Or it could have submitted evidence estimating or describing the burden for ERISA plans generally. Respondent's contentions then could have been subject to adversarial testing in the district court. But respondent's only factual submission was a "fact sheet" printed from the Internet stating that it would be less costly if States with similar statutes standardized their data formats—which says nothing about whether the cost is so great as to fundamentally affect plan administration. See J.A. 217-225; D. Ct. Doc. 59, at 2 (Oct. 7, 2012). Thus, as Judge Straub explained, "[o]n the record before [the court of appeals], there is no basis to find that the Vermont statute would cause [respondent] to increase its costs more than a *de* [*minimis*] amount to cover the cost of sending information to the state, much less that it would cause a fiduciary to change a plan in any way." Pet. App. 40-41 (dissenting in part and concurring in part).

B. The Vermont Reporting Requirements Are Valid If Reviewed Under General Principles Of Field And Conflict Preemption

In separate opinions, four Justices have called for this Court to clarify that its framework for analyzing ERISA preemption questions essentially applies ordinary principles of field and conflict preemption. Under that view, "the 'relate to' clause of the pre-emption provision is meant, not to set forth a *test* for pre-emption, but rather to identify the field in which ordinary *field pre-emption* applies—namely, the field of laws regulating 'employee benefit plan[s] described in section 1003(a) of this title and not exempt under section 1003(b) of this title,' 29 U.S.C. § 1144(a)." *Dillingham*, 519 U.S. at 336 (Scalia, J., concurring, joined by Ginsburg, J.) (brackets in original); see *Egelhoff*, 532 U.S. at 152-153 (Scalia, J., concurring, joined by Ginsburg, J.); *id.* at 153 (Breyer, J., dissenting, joined by Stevens, J.). And in *Boggs* v. *Boggs*, 520 U.S. 833 (1997), the Court held a state law preempted "by simply asking if [the] state law conflicts with the provisions of ERISA or operates to frustrate its objects," without "inquir[ing] whether the statutory phrase 'relate to' provides further and additional support for the pre-emption claim." *Id.* at 841; cf. *UNUM Life Ins. Co. of Am.* v. *Ward*, 526 U.S. 358, 375-377 (1999) (*UNUM*) (applying conflict-preemption analysis to state law falling within ERISA's insurance savings clause).

If the Court applies ordinary field and conflict preemption principles here as a means of giving content to (or checking the applicability of) the "relate to" language in Section 1144(a), the Vermont reporting requirements likewise are not preempted.

1. When a federal statute occupies a field of substantive regulation, the test for preemption "is whether the matter on which the State asserts the right to act is in any way regulated by the Federal Act." *Rice* v. *Santa Fe Elevator Corp.*, 331 U.S. 218, 236 (1947). If so, the state law is preempted, even if it is consistent with federal objectives. See *ONEOK, Inc.* v. *Learjet, Inc.*, 135 S. Ct. 1591, 1595 (2015); accord *Metropolitan Life Ins. Co.*, 471 U.S. at 739 ("[ERISA's] pre-emption provision was intended to displace all state laws that fall within its sphere, even including state laws that are consistent with ERISA's substantive requirements."). But this Court has also kept "in mind that not every state law that in some remote way may affect the [subject matter of the federal statute] can be said to fall within the pre-empted field." *English* v. *General Elec. Co.*, 496 U.S. 72, 85 (1990).

Largely for the reasons given in Point A above, the Vermont reporting requirements do not improperly invade a field governed exclusively by ERISA. They do not target ERISA plans for special treatment. They have a different purpose and function than ERISA, focusing on the quality, utilization, and cost of medical services themselves, from a healthcare-delivery perspective, rather than the design of employee benefit plans or fiduciary conduct in delivering promised benefits to ERISA participants and beneficiaries. And the requirements have not been shown to exert more than a de minimis effect on the design or administration of ERISA plans.

2. a. Under conflict-preemption principles, a state law is invalid (as applied to ERISA plans) if "compliance with both [the state law] and [ERISA] is impossible, or when the state law stands as an obstacle to

the accomplishment and execution of the full purposes and objective of [ERISA]." *United States* v. *Locke*, 529 U.S. 89, 109 (2000) (citation and internal quotation marks omitted); see *Boggs*, 520 U.S. at 844. Thus, in *Boggs*, this Court held that a state law permitting a non-participant to effect a testamentary transfer of her spouse's undistributed pension benefits was preempted after finding a "direct clash between [the] state law and the provisions and objectives of ERISA" with respect to the designation of beneficiaries of survivor annuities. 520 U.S. at 843-844. Similarly, in a line of cases, this Court has held that certain state laws conflict with the objectives of ERISA's exclusive remedial scheme. See *Aetna Health*, 542 U.S. at 214-215. A law would also be preempted if it frustrated the central purpose of Section 1144(a) itself, which is to avoid "the prospect that an employer's administrative scheme would be subject to conflicting requirements." *Fort Halifax*, 482 U.S. at 9-10.

It is not impossible to comply with both ERISA's requirements and the Vermont reporting requirements. And for the reasons given above (see pp. 22-29, *supra*), no sound basis exists to conclude that the requirements would pose an obstacle to the uniform administration of ERISA plans.

b. Respondent has contended (Br. in Opp. 22-23) that the Vermont scheme conflicts with ERISA's requirement that fiduciaries follow plan documents, 29 U.S.C. 1104(a)(1)(D), because the plan documents in this case required respondent and Blue Cross to maintain the confidentiality of the medical records of participants and beneficiaries. Respondent essentially argues that a plan sponsor can evade a state legal obligation by drafting an incompatible plan term. But

this Court rejected a materially identical argument in *UNUM*, where it held that an otherwise non-preempted state insurance law did not conflict with Section 1104(a)(1)(D) merely because a plan sponsor had "insert[ed] a contrary term in plan documents," finding that argument to "make[] scant sense." 526 U.S. at 375-376; see *FMC Corp.* v. *Holliday*, 498 U.S. 52, 54-65 (1990) (analyzing whether ERISA preempted a state law prohibiting a particular plan term under the normal ERISA preemption framework).

As support for its anomalous position, respondent cites a footnote in *Egelhoff*, *supra* (Br. in Opp. 22-24), but respondent misunderstands the import of that discussion. *Egelhoff* held preempted, as applied to ERISA plans, a Washington statute providing that the designation of a spouse as a beneficiary of a nonprobate asset was revoked automatically upon divorce. 532 U.S. at 144 (citing Wash. Rev. Code § 11.07.010(1) (1994)). The Court rejected the argument that the Washington statute was saved from preemption because employers could opt out of the automatic-revocation rule through an express plan term. See *id.* at 150-151. In the cited footnote, the Court merely observed that a State could not save an otherwise preempted law from invalidation by permitting ERISA plan sponsors to opt out by changing the terms of their plans, see *id.* at 151 n.4, and the Court went on to highlight the significant burden for fiduciaries in "maintain[ing] a familiarity with the laws of all 50 States so that they can update their plans as necessary," *id.* at 151. Nothing in the Court's discussion, however, supports the view that a state law that is otherwise *not* preempted could be circumvented by

a contrary term in a particular plan, an argument this Court rejected in *UNUM*.

In any event, there is no evident conflict between the terms of respondent's plan and the Vermont reporting requirements. No provision of respondent's plan documents states that the plan will refuse to report claims information to state authorities in compliance with state law. To the contrary, the primary plan document expressly provides that "[t]he Plan shall comply with all * * * state and federal law to the extent not preempted by ERISA." J.A. 57. Respondent appears to rely on two statements in a summary plan description stating that information relating to "well-baby programs" and "pharmagenomics" will be kept confidential. J.A. 117-120 (capitalization and emphasis omitted); see Resp. C.A. Br. 7. But respondent's primary plan document states that it trumps conflicting statements in the summary plan description, J.A. 40; the cited statements relate only to very specific medical programs; and, in any event, the extensive confidentiality protections of the Vermont scheme (see p. 6, *supra*) preserve the confidentiality of reported information, see Database Statute § 9410(e) and (h)(2) (Supp. 2014). Accordingly, even if ERISA called on courts to conduct the sort of plan-by-plan preemption analysis that respondent suggests—in which the validity of state law would be entirely subordinate to plan terms—preemption would not be warranted here.

c. Finally, respondent argued below that by complying with state-law reporting requirements, an ERISA fiduciary would violate its statutory duty to act "for the exclusive purpose of * * * providing benefits to participants and their beneficiaries; and

* * * defraying reasonable expenses of administering the plan," 29 U.S.C. 1104(a)(1); see Resp. C.A. Br. 39-40. If accepted, that argument not only would preclude States from imposing any reporting requirements, but would also bar States from imposing taxes and other generally applicable obligations on ERISA plans that serve purposes other than providing benefits and defraying administrative expenses. Congress could not have intended ERISA's fiduciary-duties provision to have that sweeping preemptive effect. And like respondent's other arguments, it cannot be squared with this Court's more circumscribed understanding of ERISA preemption or its decisions upholding state laws imposing obligations on ERISA plans.

* * * * *

For the foregoing reasons, whether under this Court's established framework for analyzing preemption questions under Section 1144(a), or viewed through the lens of ordinary field and conflict preemption, the Vermont reporting requirements are not preempted. Thus, like other record-keeping and reporting requirements incident to state tax, wage, property, and health laws, the Vermont reporting requirements are among the "myriad state laws of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not 'relate to' them within the meaning of the governing statute." *De Buono*, 520 U.S. at 815 (citation and internal quotation marks omitted).

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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SEPTEMBER 2015

APPENDIX

1. 29 U.S.C. 1001 provides:

Congressional findings and declaration of policy

(a) Benefit plans as affecting interstate commerce and the Federal taxing power

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans are carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax

treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

(c) Protection of interstate commerce, the Federal taxing power, and beneficiaries by vesting of accrued benefits, setting minimum standards of funding, requiring termination insurance

It is hereby further declared to be the policy of this chapter to protect interstate commerce, the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.

2. 29 U.S.C. 1002(1) provides:

Definitions

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section

186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

3. 29 U.S.C. 1021(a) and (b) provide:

Duty of disclosure and reporting

(a) Summary plan description and information to be furnished to participants and beneficiaries

The administrator of each employee benefit plan shall cause to be furnished in accordance with section 1024(b) of this title to each participant covered under the plan and to each beneficiary who is receiving benefits under the plan—

(1) a summary plan description described in section 1022(a)(1)[1] of this title; and

(2) the information described in subsection (f) and sections 1024(b)(3) and 1025(a) and (c) of this title.

(b) Reports to be filed with Secretary of Labor

The administrator shall, in accordance with section 1024(a) of this title, file with the Secretary—

(1) the annual report containing the information required by section 1023 of this title; and

(2) terminal and supplementary reports as required by subsection (c) of this section.

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[1] See References in Text note below.

4. 29 U.S.C. 1023 provides in pertinent part:

Annual reports

(a) Publication and filing

(1)(A) An annual report shall be published with respect to every employee benefit plan to which this part applies. Such report shall be filed with the Secretary in accordance with section 1024(a) of this title, and shall be made available and furnished to participants in accordance with section 1024(b) of this title.

(B) The annual report shall include the information described in subsections (b) and (c) and where applicable subsections (d), (e), and (f) and shall also include—

(i) a financial statement and opinion, as required by paragraph (3) of this subsection, and

(ii) an actuarial statement and opinion, as required by paragraph (4) of this subsection.

* * * * *

(3)(A) Except as provided in subparagraph (C), the administrator of an employee benefit plan shall engage, on behalf of all plan participants, an independent qualified public accountant, who shall conduct such an examination of any financial statements of the plan, and of other books and records of the plan, as the accountant may deem necessary to enable the accountant to form an opinion as to whether the financial statements and schedules required to be included in the annual reports by subsection (b) of this section are presented fairly in conformity with generally accepted

accounting principles applied on a basis consistent with that of the preceding year.

* * * * *

(4)(A) The administrator of an employee pension benefit plan subject to the reporting requirement of subsection (d) of this section shall engage, on behalf of all plan participants, an enrolled actuary who shall be responsible for the preparation of the materials comprising the actuarial statement required under subsection (d) of this section.

* * * * *

(b) Financial statement

An annual report under this section shall include a financial statement containing the following information:

(1) With respect to an employee welfare benefit plan: a statement of assets and liabilities; a statement of changes in fund balance; and a statement of changes in financial position. In the notes to financial statements, disclosures concerning the following items shall be considered by the accountant: a description of the plan including any significant changes in the plan made during the period and the impact of such changes on benefits; a description of material lease commitments, other commitments, and contingent liabilities; a description of agreements and transactions with persons known to be parties in interest; a general description of priorities upon termination of the plan; information concerning whether or not a tax ruling or determination letter has been obtained; and any other

matters necessary to fully and fairly present the financial statements of the plan.

* * * * *

(3) With respect to all employee benefit plans, the statement required under paragraph (1) or (2) shall have attached the following information in separate schedules:

(A) a statement of the assets and liabilities of the plan aggregated by categories and valued at their current value, and the same data displayed in comparative form for the end of the previous fiscal year of the plan;

(B) a statement of receipts and disbursements during the preceding twelve-month period aggregated by general sources and applications;

(C) a schedule of all assets held for investment purposes aggregated and identified by issuer, borrower, or lessor, or similar party to the transaction (including a notation as to whether such party is known to be a party in interest), maturity date, rate of interest, collateral, par or maturity value, cost, and current value;

(D) a schedule of each transaction involving a person known to be party in interest, the identity of such party in interest and his relationship or that of any other party in interest to the plan, a description of each asset to which the transaction relates; the purchase or selling price in case of a sale or purchase, the rental in case of a lease, or the interest rate and maturity date in case of a loan; expense incurred in connection with the transaction; the cost of the asset, the

current value of the asset, and the net gain (or loss) on each transaction;

(E) a schedule of all loans or fixed income obligations which were in default as of the close of the plan's fiscal year or were classified during the year as uncollectable and the following information with respect to each loan on such schedule (including a notation as to whether parties involved are known to be parties in interest): the original principal amount of the loan, the amount of principal and interest received during the reporting year, the unpaid balance, the identity and address of the obligor, a detailed description of the loan (including date of making and maturity, interest rate, the type and value of collateral, and other material terms), the amount of principal and interest overdue (if any) and an explanation thereof;

(F) a list of all leases which were in default or were classified during the year as uncollectable; and the following information with respect to each lease on such schedule (including a notation as to whether parties involved are known to be parties in interest): the type of property leased (and, in the case of fixed assets such as land, buildings, leasehold, and so forth, the location of the property), the identity of the lessor or lessee from or to whom the plan is leasing, the relationship of such lessors and lessees, if any, to the plan, the employer, employee organization, or any other party in interest, the terms of the lease regarding rent, taxes, insurance, repairs, expenses, and renewal options; the date the leased property was purchased and its cost, the date the property was leased and its approximate value at such date, the gross rental receipts during the

reporting period, expenses paid for the leased property during the reporting period, the net receipts from the lease, the amounts in arrears, and a statement as to what steps have been taken to collect amounts due or otherwise remedy the default;

(G) if some or all of the assets of a plan or plans are held in a common or collective trust maintained by a bank or similar institution or in a separate account maintained by an insurance carrier or a separate trust maintained by a bank as trustee, the report shall include the most recent annual statement of assets and liabilities of such common or collective trust, and in the case of a separate account or a separate trust, such other information as is required by the administrator in order to comply with this subsection; and

(H) a schedule of each reportable transaction, the name of each party to the transaction (except that, in the case of an acquisition or sale of a security on the market, the report need not identify the person from whom the security was acquired or to whom it was sold) and a description of each asset to which the transaction applies; the purchase or selling price in case of a sale or purchase, the rental in case of a lease, or the interest rate and maturity date in case of a loan; expenses incurred in connection with the transaction; the cost of the asset, the current value of the asset, and the net gain (or loss) on each transaction. For purposes of the preceding sentence, the term "reportable transaction" means a transaction to which the plan is a party if such transaction is—

(i) a transaction involving an amount in excess of 3 percent of the current value of the assets of the plan;

(ii) any transaction (other than a transaction respecting a security) which is part of a series of transactions with or in conjunction with a person in a plan year, if the aggregate amount of such transactions exceeds 3 percent of the current value of the assets of the plan;

(iii) a transaction which is part of a series of transactions respecting one or more securities of the same issuer, if the aggregate amount of such transactions in the plan year exceeds 3 percent of the current value of the assets of the plan; or

(iv) a transaction with or in conjunction with a person respecting a security, if any other transaction with or in conjunction with such person in the plan year respecting a security is required to be reported by reason of clause (i).

(4) The Secretary may, by regulation, relieve any plan from filing a copy of a statement of assets and liabilities (or other information) described in paragraph (3)(G) if such statement and other information is filed with the Secretary by the bank or insurance carrier which maintains the common or collective trust or separate account.

(c) Information to be furnished by administrator

The administrator shall furnish as a part of a report under this section the following information:

(1) The number of employees covered by the plan.

(2) The name and address of each fiduciary.

(3) Except in the case of a person whose compensation is minimal (determined under regulations of the Secretary) and who performs solely ministerial duties (determined under such regulations), the name of each person (including but not limited to, any consultant, broker, trustee, accountant, insurance carrier, actuary, administrator, investment manager, or custodian who rendered services to the plan or who had transactions with the plan) who received directly or indirectly compensation from the plan during the preceding year for services rendered to the plan or its participants, the amount of such compensation, the nature of his services to the plan or its participants, his relationship to the employer of the employees covered by the plan, or the employee organization, and any other office, position, or employment he holds with any party in interest.

(4) An explanation of the reason for any change in appointment of trustee, accountant, insurance carrier, enrolled actuary, administrator, investment manager, or custodian.

(5) Such financial and actuarial information including but not limited to the material described in subsections (b) and (d) of this section as the Secretary may find necessary or appropriate.

(d) Actuarial statement

With respect to an employee pension benefit plan (other than (A) a profit sharing, savings, or other plan, which is an individual account plan, (B) a plan described in section 1081(b) of this title, or (C) a plan described both in

section 1321(b) of this title and in paragraph (1), (2), (3), (4), (5), (6), or (7) of section 1081(a) of this title) an annual report under this section for a plan year shall include a complete actuarial statement applicable to the plan year which shall include the following:

* * * * *

(e) Statement from insurance company, insurance service, or other similar organizations which sell or guarantee plan benefits

If some or all of the benefits under the plan are purchased from and guaranteed by an insurance company, insurance service, or other similar organization, a report under this section shall include a statement from such insurance company, service, or other similar organization covering the plan year and enumerating—

(1) the premium rate or subscription charge and the total premium or subscription charges paid to each such carrier, insurance service, or other similar organization and the approximate number of persons covered by each class of such benefits; and

(2) the total amount of premiums received, the approximate number of persons covered by each class of benefits, and the total claims paid by such company, service, or other organization; dividends or retroactive rate adjustments, commissions, and administrative service or other fees or other specific acquisition costs paid by such company, service, or other organization; any amounts held to provide benefits after retirement; the remainder of such premiums; and the names and addresses of the brokers, agents, or other persons to whom commissions or fees were paid, the amount paid

to each, and for what purpose. If any such company, service, or other organization does not maintain separate experience records covering the specific groups it serves, the report shall include in lieu of the information required by the foregoing provisions of this paragraph (A) a statement as to the basis of its premium rate or subscription charge, the total amount of premiums or subscription charges received from the plan, and a copy of the financial report of the company, service, or other organization and (B) if such company, service, or organization incurs specific costs in connection with the acquisition or retention of any particular plan or plans, a detailed statement of such costs.

(f) Additional information with respect to defined benefit plans

(1) Liabilities under 2 or more plans

(A) In general

In any case in which any liabilities to participants or their beneficiaries under a defined benefit plan as of the end of a plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under 2 or more pension plans as of immediately before such plan year, an annual report under this section for such plan year shall include the funded percentage of each of such 2 or more pension plans as of the last day of such plan year and the funded percentage of the plan with respect to which the annual report is filed as of the last day of such plan year.

* * * * *

5. 29 U.S.C. 1024 provides in pertinent part:

Filing with Secretary and furnishing information to participants and certain employers

(a) Filing of annual report with Secretary

(1) The administrator of any employee benefit plan subject to this part shall file with the Secretary the annual report for a plan year within 210 days after the close of such year (or within such time as may be required by regulations promulgated by the Secretary in order to reduce duplicative filing). The Secretary shall make copies of such annual reports available for inspection in the public document room of the Department of Labor.

(2)(A) With respect to annual reports required to be filed with the Secretary under this part, he may by regulation prescribe simplified annual reports for any pension plan which covers less than 100 participants.

(B) Nothing contained in this paragraph shall preclude the Secretary from requiring any information or data from any such plan to which this part applies where he finds such data or information is necessary to carry out the purposes of this subchapter nor shall the Secretary be precluded from revoking provisions for simplified reports for any such plan if he finds it necessary to do so in order to carry out the objectives of this subchapter.

(3) The Secretary may by regulation exempt any welfare benefit plan from all or part of the reporting and disclosure requirements of this subchapter, or may provide for simplified reporting and disclosure if

he finds that such requirements are inappropriate as applied to welfare benefit plans.

* * * * *

6. 29 U.S.C. 1104(a)(1) provides:

Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter.

7. 29 U.S.C. 1134(a) provides in pertinent part:

Investigative authority

(a) Investigation and submission of reports, books, etc.

The Secretary shall have the power, in order to determine whether any person has violated or is about to violate any provision of this subchapter or any regulation or order thereunder—

(1) to make an investigation, and in connection therewith to require the submission of reports, books, and records, and the filing of data in support of any information required to be filed with the Secretary under this subchapter, and

(2) to enter such places, inspect such books and records and question such persons as he may deem necessary to enable him to determine the facts relative to such investigation, if he has reasonable cause to believe there may exist a violation of this subchapter or any rule or regulation issued thereunder or if the entry is pursuant to an agreement with the plan.

* * * * *

8. 29 U.S.C. 1143(a) provides:

Research, studies, and reports

(a) Authorization to undertake research and surveys

(1) The Secretary is authorized to undertake research and surveys and in connection therewith to collect, compile, analyze and publish data, information, and sta-

tistics relating to employee benefit plans, including retirement, deferred compensation, and welfare plans, and types of plans not subject to this chapter.

(2) The Secretary is authorized and directed to undertake research studies relating to pension plans, including but not limited to (A) the effects of this subchapter upon the provisions and costs of pension plans, (B) the role of private pensions in meeting the economic security needs of the Nation, and (C) the operation of private pension plans including types and levels of benefits, degree of reciprocity or portability, and financial and actuarial characteristics and practices, and methods of encouraging the growth of the private pension system.

(3) The Secretary may, as he deems appropriate or necessary, undertake other studies relating to employee benefit plans, the matters regulated by this subchapter, and the enforcement procedures provided for under this subchapter.

(4) The research, surveys, studies, and publications referred to in this subsection may be conducted directly, or indirectly through grant or contract arrangements.

9. 29 U.S.C. 1144 provides in pertinent part:

Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of

this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * * * *

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section—

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

* * * * *

(7) Subsection (a) of this section shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title), qualified medical child support orders (within the meaning of section 1169(a)(2)(A) of this title), and the provisions of law referred to in section 1169(a)(2)(B)(ii) of this title to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action—

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 1191 of this title.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

* * * * *

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede

any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

10. 29 U.S.C. 1185d provides:

Additional market reforms

(a) General rule

Except as provided in subsection (b)—

(1) the provisions of part A of title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.] (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart; and

(2) to the extent that any provision of this part conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

(b) Exception

Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act [42 U.S.C. 300gg-16, 300gg-18] (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this part shall continue to apply to

such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.

11. 29 U.S.C. 1191(a) provides:

Preemption; State flexibility; construction

(a) **Continued applicability of State law with respect to health insurance issuers**

(1) **In general**

Subject to paragraph (2) and except as provided in subsection (b) of this section, this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

(2) **Continued preemption with respect to group health plans**

Nothing in this part shall be construed to affect or modify the provisions of section 1144 of this title with respect to group health plans.

12. 29 U.S.C. 1191b(a)-(b) provides in pertinent part:

Definitions

(a) Group health plan

For purposes of this part—

(1) In general

The term "group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care (as defined in paragraph (2) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) Medical care

The term "medical care" means amounts paid for—

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

(b) Definitions relating to health insurance

For purposes of this part—

(1) Health insurance coverage

The term "health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(2) Health insurance issuer

The term "health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 1144(b)(2) of this title). Such term does not include a group health plan.

* * * * *

13. 42 U.S.C. 300gg-15a provides:

Provision of additional information

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall comply with the provisions of section 18031(e)(3) of this title, except that a plan or coverage that is not offered through an Exchange shall only be required to submit the information required to the Secretary and

the State insurance commissioner, and make such information available to the public.

14. 42 U.S.C. 300gg-17 provides in pertinent part:

Ensuring the quality of care

(a) Quality reporting

(1) In general

Not later than 2 years after March 23, 2010, the Secretary, in consultation with experts in health care quality and stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that—

(A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602[1] of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage;

(B) implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge

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[1] See References in Text note below.

planning, and post discharge reinforcement by an appropriate health care professional;

(C) implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and

(D) implement wellness and health promotion activities.

(2) Reporting requirements

(A) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary, and to enrollees under the plan or coverage, a report on whether the benefits under the plan or coverage satisfy the elements described in subparagraphs (A) through (D) of paragraph (1).

* * * * *

(b) Wellness and prevention programs

For purposes of subsection (a)(1)(D), wellness and health promotion activities may include personalized wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of

the program's participants, and which may include the following wellness and prevention efforts:

(1) Smoking cessation.

(2) Weight management.

(3) Stress management.

(4) Physical fitness.

(5) Nutrition.

(6) Heart disease prevention.

(7) Healthy lifestyle support.

(8) Diabetes prevention.

* * * * *

(d) Regulations

Not later than 2 years after March 23, 2010, the Secretary shall promulgate regulations that provide criteria for determining whether a reimbursement structure is described in subsection (a).

(e) Study and report

Not later than 180 days after the date on which regulations are promulgated under subsection (c),[2] the Government Accountability Office shall review such regulations and conduct a study and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report regarding the impact

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[2] So in original. Probably should be "subsection (d),".

the activities under this section have had on the quality and cost of health care.

15. 42 U.S.C. 300gg-23(a) provides:

Preemption; State flexibility; construction

(a) Continued applicability of State law with respect to health insurance issuers

(1) In general

Subject to paragraph (2) and except as provided in subsection (b) of this section, this part and part C of this subchapter insofar as it relates to this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual or group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

(2) Continued preemption with respect to group health plans

Nothing in this part shall be construed to affect or modify the provisions of section 1144 of title 29 with respect to group health plans.

16. 42 U.S.C. 1315a provides in pertinent part:

Center for Medicare and Medicaid Innovation

(a) Center for Medicare and Medicaid Innovation established

(1) In general

There is created within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation (in this section referred to as the "CMI") to carry out the duties described in this section. The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures under the applicable subchapters while preserving or enhancing the quality of care furnished to individuals under such subchapters. In selecting such models, the Secretary shall give preference to models that also improve the coordination, quality, and efficiency of health care services furnished to applicable individuals defined in paragraph (4)(A).

* * * * *

(b) Testing of models (phase I)

(1) In general

The CMI shall test payment and service delivery models in accordance with selection criteria under paragraph (2) to determine the effect of applying such models under the applicable subchapter (as defined in subsection (a)(4)(B)) on program expenditures under such subchapters and the quality of care received by individuals receiving benefits under such subchapter.

(2) Selection of models to be tested

(A) In general

The Secretary shall select models to be tested from models where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The Secretary shall focus on models expected to reduce program costs under the applicable subchapter while preserving or enhancing the quality of care received by individuals receiving benefits under such subchapter. The models selected under this subparagraph may include, but are not limited to, the models described in subparagraph (B).

(B) Opportunities

The models described in this subparagraph are the following models:

* * * * *

(xi) Allowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals.

* * * * *

(4) Evaluation

(A) In general

The Secretary shall conduct an evaluation of each model tested under this subsection. Such evaluation shall include an analysis of—

(i) the quality of care furnished under the model, including the measurement of patient-level outcomes and patient-centeredness criteria determined appropriate by the Secretary; and

(ii) the changes in spending under the applicable subchapters by reason of the model.

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17. 42 U.S.C. 1395kk(e) (as amended by Pub. L. No. 114-10, § 105(c), 129 Stat. 137) provides in pertinent part:

Administration of insurance programs

(e) Availability of data

(1) In general

Subject to paragraph (4), the Secretary shall make available to qualified entities (as defined in paragraph (2)) data described in paragraph (3) for the evaluation of the performance of providers of services and suppliers.

(2) Qualified entities

For purposes of this subsection, the term "qualified entity" means a public or private entity that—

(A) is qualified (as determined by the Secretary) to use claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use; and

(B) agrees to meet the requirements described in paragraph (4) and meets such other requirements as the Secretary may specify, such as ensuring security of data.

(3) Data described

The data described in this paragraph are standardized extracts (as determined by the Secretary) of claims data under parts A, B, and D for items and services furnished under such parts for one or more specified geographic areas and time periods requested by a qualified entity. Beginning July 1, 2016, if the Secretary determines appropriate, the data described in this paragraph may also include standardized extracts (as determined by the Secretary) of claims data under subchapters XIX and XXI for assistance provided under such subchapters for one or more specified geographic areas and time periods requested by a qualified entity. The Secretary shall take such actions as the Secretary deems necessary to protect the identity of individuals entitled to or enrolled for benefits under such parts or under subchapters[2] XIX or XXI.

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[2] So in original. Probably should be "subchapter".

18. 42 U.S.C. 18031(e)(3) provides:

Affordable choices of health benefit plans

(e) Certification

(3) Transparency in coverage

(A) In general

The Exchange shall require health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, the State insurance commissioner, and make available to the public, accurate and timely disclosure of the following information:

(i) Claims payment policies and practices.

(ii) Periodic financial disclosures.

(iii) Data on enrollment.

(iv) Data on disenrollment.

(v) Data on the number of claims that are denied.

(vi) Data on rating practices.

(vii) Information on cost-sharing and payments with respect to any out-of-network coverage.

(viii) Information on enrollee and participant rights under this title.[3]

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[3] See References in Text note below.

(ix) Other information as determined appropriate by the Secretary.

(B) Use of plain language

The information required to be submitted under subparagraph (A) shall be provided in plain language. The term "plain language" means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing. The Secretary and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing.

(C) Cost sharing transparency

The Exchange shall require health plans seeking certification as qualified health plans to permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information shall be made available to such individual through an Internet website and such other means for individuals without access to the Internet.

(D) Group health plans

The Secretary of Labor shall update and harmonize the Secretary's rules concerning the accu-

rate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, and periodic financial disclosure with the standards established by the Secretary under subparagraph (A).

19. 42 U.S.C. 18041(d) provides:

State flexibility in operation and enforcement of Exchanges and related requirements

(d) No interference with State regulatory authority

Nothing in this title[1] shall be construed to preempt any State law that does not prevent the application of the provisions of this title.[1]

20. Vt. Stat. Ann. tit. 18, § 9401 (2012) provides:

Policy

(a) It is the policy of the state of Vermont that health care is a public good for all Vermonters and to ensure that all residents have access to quality health services at costs that are affordable. To achieve this policy, it is necessary that the state ensure the quality of health care services provided in Vermont and, until health care systems are successful in controlling their costs and resources, to oversee cost containment.

(b) It is further the policy of the state of Vermont that the health care system should:

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[1] See references in Text note below.

(1) Maintain and improve the quality of health care services offered to Vermonters.

(2) Utilize planning, market, and other mechanisms that contain or reduce increases in the cost of delivering services so that health care costs do not consume a disproportionate share of Vermonters' incomes or the moneys available for other services required to insure the health, safety, and welfare of Vermonters.

(3) Encourage regional and local participation in decisions about health care delivery, financing, and provider supply.

(4) Utilize planning, market, and other mechanisms that will achieve rational allocation of health care resources in the state.

(5) Facilitate universal access to preventive and medically necessary health care.

(6) Support efforts to integrate mental health and substance abuse services with overall medical care.

21. Vt. Stat. Ann. tit. 18, § 9402(8) (2012) provides:

Definitions

(8) "Health insurer" means any health insurance company, nonprofit hospital and medical service corporation, managed care organizations, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities.

22. Vt. Stat. Ann. tit. 18, § 9410 (Supp. 2014) provides:

Health care database

(a)(1) The Board shall establish and maintain a unified health care database to enable the Commissioner and the Board to carry out their duties under this chapter, chapter 220 of this title, and Title 8, including:

(A) determining the capacity and distribution of existing resources;

(B) identifying health care needs and informing health care policy;

(C) evaluating the effectiveness of intervention programs on improving patient outcomes;

(D) comparing costs between various treatment settings and approaches;

(E) providing information to consumers and purchasers of health care; and

(F) improving the quality and affordability of patient health care and health care coverage.

(2)(A) The program authorized by this section shall include a consumer health care price and quality information system designed to make available to consumers transparent health care price information, quality information, and such other information as the Board determines is necessary to empower individuals, including uninsured individuals, to make economically sound and medically appropriate decisions.

(B) The Commissioner may require a health insurer covering at least five percent of the lives covered in the insured market in this State to file with the Commissioner a consumer health care price and quality information plan in accordance with rules adopted by the Commissioner.

(C) The Board shall adopt such rules as are necessary to carry out the purposes of this subdivision. The Board's rules may permit the gradual implementation of the consumer health care price and quality information system over time, beginning with health care price and quality information that the Board determines is most needed by consumers or that can be most practically provided to the consumer in an understandable manner. The rules shall permit health insurers to use security measures designed to allow subscribers access to price and other information without disclosing trade secrets to individuals and entities who are not subscribers. The rules shall avoid unnecessary duplication of efforts relating to price and quality reporting by health insurers, health care providers, health care facilities, and others, including activities undertaken by hospitals pursuant to their community report obligations under section 9405b of this title.

(b) The database shall contain unique patient and provider identifiers and a uniform coding system, and shall reflect all health care utilization, costs, and resources in this State, and health care utilization and costs for services provided to Vermont residents in another state.

(c) Health insurers, health care providers, health care facilities, and governmental agencies shall file reports, data, schedules, statistics, or other information determined by the Board to be necessary to carry out the purposes of this section. Such information may include:

(1) health insurance claims and enrollment information used by health insurers;

(2) information relating to hospitals filed under subchapter 7 of this chapter (hospital budget reviews); and

(3) any other information relating to health care costs, prices, quality, utilization, or resources required by the Board to be filed.

(d) The Board may by rule establish the types of information to be filed under this section, and the time and place and the manner in which such information shall be filed.

(e) Records or information protected by the provisions of the physician-patient privilege under 12 V.S.A. § 1612(a), or otherwise required by law to be held confidential, shall be filed in a manner that does not disclose the identity of the protected person.

(f) The Board shall adopt a confidentiality code to ensure that information obtained under this section is handled in an ethical manner.

(g) Any person who knowingly fails to comply with the requirements of this section or rules adopted pursuant to this section shall be subject to an administrative penalty of not more than $1,000.00 per violation.

The Board may impose an administrative penalty of not more than $10,000.00 each for those violations the Board finds were willful. In addition, any person who knowingly fails to comply with the confidentiality requirements of this section or confidentiality rules adopted pursuant to this section and uses, sells, or transfers the data or information for commercial advantage, pecuniary gain, personal gain, or malicious harm shall be subject to an administrative penalty of not more than $50,000.00 per violation. The powers vested in the Board by this subsection shall be in addition to any other powers to enforce any penalties, fines, or forfeitures authorized by law.

(h)(1) All health insurers shall electronically provide to the Board in accordance with standards and procedures adopted by the Board by rule:

(A) their health insurance claims data, provided that the Board may exempt from all or a portion of the filing requirements of this subsection data reflecting utilization and costs for services provided in this State to residents of other states;

(B) cross-matched claims data on requested members, subscribers, or policyholders; and

(C) member, subscriber, or policyholder information necessary to determine third party liability for benefits provided.

(2) The collection, storage, and release of health care data and statistical information that is subject to the federal requirements of the Health Insurance Portability and Accountability Act ("HIPAA") shall be

governed exclusively by the regulations adopted thereunder in 45 C.F.R. Parts 160 and 164.

(A) All health insurers that collect the Health Employer Data and Information Set (HEDIS) shall annually submit the HEDIS information to the Board in a form and in a manner prescribed by the Board.

(B) All health insurers shall accept electronic claims submitted in Centers for Medicare and Medicaid Services format for UB-92 or HCFA-1500 records, or as amended by the Centers for Medicare and Medicaid Services.

(3)(A) The Board shall collaborate with the Agency of Human Services and participants in the Agency's initiatives in the development of a comprehensive health care information system. The collaboration is intended to address the formulation of a description of the data sets that will be included in the comprehensive health care information system, the criteria and procedures for the development of limited-use data sets, the criteria and procedures to ensure that HIPAA compliant limited-use data sets are accessible, and a proposed time frame for the creation of a comprehensive health care information system.

(B) To the extent allowed by HIPAA, the data shall be available as a resource for insurers, employers, providers, purchasers of health care, and State agencies to continuously review health care utilization, expenditures, and performance in Vermont. In presenting data for public access, comparative considerations shall be made regarding geography, de-

mographics, general economic factors, and institutional size.

(C) Consistent with the dictates of HIPAA, and subject to such terms and conditions as the Board may prescribe by rule, the Vermont Program for Quality in Health Care shall have access to the unified health care database for use in improving the quality of health care services in Vermont. In using the database, the Vermont Program for Quality in Health Care shall agree to abide by the rules and procedures established by the Board for access to the data. The Board's rules may limit access to the database to limited-use sets of data as necessary to carry out the purposes of this section.

(D) Notwithstanding HIPAA or any other provision of law, the comprehensive health care information system shall not publicly disclose any data that contains direct personal identifiers. For the purposes of this section, "direct personal identifiers" include information relating to an individual that contains primary or obvious identifiers, such as the individual's name, street address, e-mail address, telephone number, and Social Security number.

(i) On or before January 15, 2008 and every three years thereafter, the Commissioner shall submit a recommendation to the General Assembly for conducting a survey of the health insurance status of Vermont residents. The provisions of 2 V.S.A. § 20(d) (expiration of required reports) shall not apply to the report to be made under this subsection.

(j)(1) As used in this section, and without limiting the meaning of subdivision 9402(8) of this title, the term "health insurer" includes:

(A) any entity defined in subdivision 9402(8) of this title;

(B) any third party administrator, any pharmacy benefit manager, any entity conducting administrative services for business, and any other similar entity with claims data, eligibility data, provider files, and other information relating to health care provided to a Vermont resident, and health care provided by Vermont health care providers and facilities required to be filed by a health insurer under this section;

(C) any health benefit plan offered or administered by or on behalf of the State of Vermont or an agency or instrumentality of the State; and

(D) any health benefit plan offered or administered by or on behalf of the federal government with the agreement of the federal government.

(2) The Board may adopt rules to carry out the provisions of this subsection, including criteria for the required filing of such claims data, eligibility data, provider files, and other information as the Board determines to be necessary to carry out the purposes of this section and this chapter.

23. Reg. H-2008-01, 21-040-021 Vt. Code R. (2008) provides in pertinent part:

Section 1. Purpose.

The purpose of this rule is to set forth the requirements for the submission of health care claims data, member eligibility data, and other information relating to health care provided to Vermont residents or by Vermont health care providers and facilities by health insurers, managed care organizations, third party administrators, pharmacy benefit managers and others to the Department of Banking, Insurance, Securities and Health Care Administration and conditions for the use and dissemination of such claims data, all as required by and consistent with the purposes of 18 V.S.A. § 9410.

* * * * *

Section 3. Definitions.

As used in this Rule

* * * * *

I. "Data set" means a collection of individual data records, whether in electronic or manual files.

* * * * *

K. "De-identified health information" means information that does not identify an individual patient, member or enrollee and with respect to which no reasonable basis exists to believe that the information can be used to identify an individual patient, member or enrollee. De-identification means that health infor-

mation is not individually identifiable and requires the removal of Direct Personal Identifiers associated with patients, members or enrollees.

L. "Direct personal identifiers" is information relating to an individual patient, member or enrollee that contains primary or obvious identifiers, including:

(1) Names;

(2) Business names when that name would serve to identify a person;

(3) Postal address information other than town or city, state, and 5-digit zip code;

(4) Specific latitude and longitude or other geographic information that would be used to derive postal address;

(5) Telephone and fax numbers;

(6) Electronic mail addresses;

(7) Social security numbers;

(8) Vehicle Identifiers and serial numbers, including license plate numbers;

(9) Medical record numbers;

(10) Health plan beneficiary numbers;

(11) Certificate and license numbers;

(12) Internet protocol (IP) addresses and uniform resource locators (URL) that identify a business that would serve to identify a person;

(13) Biometric identifiers, including finger and voice prints; and

(14) Personal photographic images.

* * * * *

P. "Health benefit plan" means a policy, contract, certificate or agreement entered into, or offered by a health insurer to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Q. "Healthcare claims data" means information consisting of or derived directly from member eligibility files, medical claims files, pharmacy claims files and other related data pursuant to the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) in effect at the time of the data submission. "Healthcare claims data" does not include analysis, reports, or studies containing information from health care claims data sets if those analyses, reports, or studies have already been released in response to another request for information or as part of a general distribution of public information by BISHCA.

* * * * *

T. "Health care" means care, services, or supplies related to the health of an individual. It includes but is not limited to (1) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and (2) sale or dis-

pensing of a drug, device, equipment, or other item in accordance with a prescription [45 CFR § 160.103].

U. "Health care facility" shall be defined as per 18 V.S.A § 9432, as amended from time to time.

V. "Health care provider" means a person, partnership, corporation, facility or institution, licensed or certified or authorized by law to provide professional health care service in this state to an individual during that individual's medical care, treatment or confinement, as per 18 V.S.A. § 9432.

W. "Health information" means any information, whether oral or recorded in any form or medium, that 1) is created or received by a health-care provider, health plan, public health authority, employer, life insurer, school or university, or health-care clearinghouse; and 2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual shall be as defined in 45 CFR § 160.103.

X. "Health insurer" means those entities defined in 18 V.S.A. §§ 9402 and 9410(j)(1), and includes any health insurance company, nonprofit hospital and medical service corporation, managed care organization, third party administrator, pharmacy benefit manager, and any entity conducting administrative services for business or possessing claims data, eligibility data, provider files, and other information relating to health care provided to Vermont residents or by Vermont health care providers and facilities. The term may

also include, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities.

* * * * *

Z. "Indirect personal identifiers" means information relating to an individual patient, member or enrollee that a person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods could apply to render such information individually identifiable by using such information alone or in combination with other reasonably available information.

* * * * *

Ab. "Mandated Reporter" means a health insurer as defined herein and at 18 V.S.A. § 9410(j)(1) with two hundred (200) or more enrolled or covered members in each month during a calendar year, including both Vermont residents and any non-residents receiving covered services provided by Vermont health care providers and facilities.

Ac. "Medical claims file" means a data file composed of service level remittance information for all non-denied adjudicated claims for each billed service including, but not limited to member demographics, provider information, charge/payment information, and clinical diagnosis and procedure codes, and shall include all claims related to behavioral or mental health.

Ad. "Member" means the insured subscriber and any spouse and/or dependent covered by the subscriber's policy.

Ae. "Member eligibility file" means a data file containing demographic information for each individual member eligible for medical or pharmacy benefits for one or more days of coverage at any time during the reporting month.

* * * * *

Ag. "Payer" means a third-party payer or third-party administrator.

* * * * *

Ai. "Personal identifiers" means information relating to an individual that contains direct or indirect identifiers to which a reasonable basis exists to believe that the information can be used to identify an individual.

* * * * *

Ak. "Pharmacy claims file" means a data file containing service level remittance information from all non-denied adjudicated claims for each prescription including, but not limited to: member demographics; provider information; charge/payment information; and national drug codes.

* * * * *

Aq. "Third-party Administrator" means any person who, on behalf of a health insurer or purchaser of health benefits, receives or collects charges, contribu-

tions or premiums for, or adjusts or settles claims on or for residents of this State or Vermont health care providers and facilities.

Ar. "Vermont Healthcare Claims Uniform Reporting and Evaluation System" or "VHCURES" means the Department's system for the collection, management and reporting of eligibility, claims and related data submitted pursuant to 18 V.S.A. § 9410.

As. "Voluntary Reporter" includes any entity other than a mandated reporter, including any health benefit plan offered or administered by or on behalf of the federal government where such plan, with the agreement of the federal government, voluntarily submits data to the BISHCA commissioner for inclusion in the database on such terms as may be appropriate.

Section 4. Reporting Requirements.

Registration and Reporting Requirements

A. VHCURES Reporter Registration. On an annual basis prior to December 31, Health Insurers shall register with the Department on a form established by the Commissioner and identify whether health care claims are being paid for members who are Vermont residents and whether health care claims are being paid for non-residents receiving covered services from Vermont health care providers or facilities. Where applicable, the completed form shall identify the types of files to be submitted per Section 5. This form shall be submitted to BISHCA or its designee. See Appendix F.

B. Third Party Administrator Registration. Any person or entity that provides third party admin-

istration services, a third party administrator or "TPA" as defined in Section 3, shall register with the Department on a form established by the Commissioner, both before doing business in Vermont and on an annual basis prior to December 31 thereafter. 18 V.S.A. § 9410. See Appendix G.

C. Pharmacy Benefit Manager Registration. Any person or entity that performs pharmacy benefit management (a pharmacy benefit manager or "PBM") shall register with the Department on a form established by the Commissioner both before doing business in Vermont and on an annual basis prior to December 31. 18 V.S.A. § 9421. The registration requirement includes persons or entities in a contractual or employment relationship with a health insurer or PBM performing pharmacy benefit management for a health plan with Vermont enrollees or beneficiaries. 18 V.S.A. § 9471. See Appendix H.

D. Health Insurers shall regularly submit medical claims data, pharmacy claims data, member eligibility data, provider data, and other information relating to health care provided to Vermont residents and health care provided by Vermont health care providers and facilities to both Vermont residents and nonresidents in specified electronic format to the Department for each health line of business (Comprehensive Major Medical, TPA/ASO, Medicare Supplemental, Medicare Part C, and Medicare Part D) per the data submission requirements contained in the appendices to this Rule.

E. Voluntary Reporters may, with the permission of the Commissioner, participate in VHCURES and

submit medical claims files, pharmacy claims files, member eligibility files, provider data, and other information relating to health care provided to Vermont residents and health care provided by Vermont health care providers and facilities to both Vermont residents and non-residents in specified electronic format to the Department per the data submission requirements contained in the appendices to this Rule.

Section 5. Required Healthcare Data Files.

Mandated Reporters shall submit to BISHCA or its designee health care claims data for all members who are Vermont residents and all non-residents who received covered services provided by Vermont health care providers or facilities in accordance with the requirements of this section. Each Mandated Reporter is also responsible for the submission of all health care claims processed by any sub-contractor on its behalf unless such subcontractor is already submitting the identical data as a Mandated Reporter in its own right. The health care claims data submitted shall include, where applicable, a member eligibility file containing records associated with each of the claims files reported: a medical claims file and a pharmacy claims file. The data submitted shall also include supporting definition files for payer specific provider specialty taxonomy codes and procedure and/or diagnosis codes.

A. General Requirements for Data Submission

* * * * *

(5) Codes and Encryption Requirements

(a) Code Sources. Unless otherwise specified in this regulation, the code sources listed and described in Appendix A shall be utilized in association with the member eligibility file and medical and pharmacy claims file submissions.

(b) Member Identification Code. Reporters shall assign to each of their members a unique identification code that is the member's social security number. If a Reporter does not collect the social security numbers for all members, the Reporter shall use the social security number of the subscriber and then assign a discrete two-digit suffix for each member under the subscriber's contract.

If the subscriber's social security number is not collected by the Reporter, a version of the subscriber's certificate or contract number shall be used in its place. The discrete two-digit suffix shall also be used with the certificate or contract number. The certificate or contract number with the two-digit suffix shall be at least eleven but not more than sixty-four characters in length.

The social security number of the member/subscriber and the subscriber and member names shall be encrypted prior to submission by the Reporter utilizing a standard encryp-

tion methodology provided by BISHCA or its designee. The unique member identification code assigned by each Reporter shall remain with each member/subscriber for the entire period of coverage for that individual.

* * * * *

(8) Denied Claims. Denied claims shall be excluded from all medical and pharmacy claims file submissions. When a claim contains both fully processed/paid service lines and partially processed or denied service lines, only the fully processed/paid service lines shall be included as part of the health care claims data set submittal.

* * * * *

B. Detailed File Specifications.

(1) Filled Fields. All required fields shall be filled where applicable. Non-required text, date, and integer fields shall be set to null when unavailable. Non-applicable decimal fields shall be filled with one zero and shall not include decimal points when unavailable.

(2) Position. All text fields are to be left justified. All integer and decimal fields are to be right justified.

(3) Signs. Positive values are assumed and need not be indicated as such. Negative values must be indicated with a minus sign and must appear in the left-most position of all integer and

decimal fields. Over-punched signed integers or decimals are not to be utilized.

(4) Individual Elements and Mapping. Individual data elements, data types, field lengths, field description/code assignments, and mapping locators (UB-04, HCFA 1500, ANSI X12N 270/271, 835, 837) for each file shall be as detailed in the following appendices:

(a)

(1) Member Eligibility File Specifications —Appendix C-1

(2) Member Eligibility File Mapping to National Standard Formats—Appendix C-2

(b)

(1) Medical Claims File Specifications— Appendix D-1

(2) Medical Claims File Mapping to National Standard Formats—Appendix D-2

(c)

(1) Pharmacy Claims File Specifications— Appendix E-1

(2) Pharmacy Claims File Mapping to National Standard Formats—Appendix E-2

Section 6. Submission Requirements.

Data submission requirements shall be as detailed in the attached appendices.

A. Registration Form. It is the responsibility of each Health Insurer to resubmit or amend the regis-

tration form required by Section 4 (A) whenever modifications occur relative to the data files or contact information.

B. File Organization. The member eligibility file, medical claims file and pharmacy claims file shall be submitted to BISHCA or its designee as separate ASCII files. Each record shall terminate with a carriage return (ASCII 13) or a carriage return line feed (ASCII 13, ASCII 10).

C. Filing Media. Files shall be submitted utilizing one of the following media: diskette (1.44 MB), CD-ROM (650 MB), DVD, secure SSL web upload interface, or electronic transmission through a File Transfer Protocol. E-mail attachments shall not be accepted. Space permitting, multiple data files may be submitted utilizing the same media if the external label identifies the multiple files.

D. Transmittal Sheet. All file submissions on physical media shall be accompanied by a hard copy transmittal sheet containing the following information: identification of the Reporter, file name, type of file, data period(s), date sent, record count(s) for the file(s), and a contact person with telephone number and E-mail address. The information on the transmittal sheet shall match the information on the header and trailer records. See Appendix I.

E. Testing of Files. At least sixty days prior to the initial submission of the files or whenever the data element content of the files as described in Section 5 is subsequently altered, each Reporter shall submit to BISHCA or its desigee a data set for comparison to

the standards listed in Section 7. The size, based upon a calendar period of one month, quarter, or year, of the data files submitted shall correspond to the filing period established for each Reporter under subsection I of this Section.

F. Rejection of Files. Failure to conform to subsections A, B, or C of this Section shall result in the rejection and return of the applicable data file(s). All rejected and returned files shall be resubmitted in the appropriate, corrected form to BISHCA or its designee within 10 days.

* * * * *

Section 8. Procedures for the Approval and Release of Claims Data.

The requirements, procedures and conditions under which persons other than the Department may have access to health care claims data sets and related information received or generated by the Department or its designee pursuant to this regulation shall depend upon the requestor and the characteristics of the particular information requested, all as set forth below.

A. Classification of Data Elements

(1) Unrestricted Data Elements: Data elements designated in Appendix J as "Unrestricted" shall be available for general use and public release as part of a Public Use File.

(2) Restricted Data Elements: Data elements designated in Appendix J as "Restricted" shall not be available for use and release outside the Department except as part of a Limited Use Research

Health Care Claims Data Set approved by the commissioner pursuant to the requirements of this regulation.

(3) Unavailable Data Elements: Data elements which are not designated in Appendix J as either Unrestricted or Restricted, or are designated as "Unavailable", shall not be available for release or use outside the Department in any data set or disclosed in publicly released reports in any circumstance.

* * * * *

C. Limited Use Health Care Claims Research Data Sets—Release and Availability

* * * * *

(2) The Commissioner may approve the release of limited use data sets only when the Commissioner is satisfied as to the following:

(a) The application submitted is complete and the requesting individuals or entities and principal investigator have signed a data use agreement as specified;

(b) Procedures to ensure the confidentiality of any patient and any confidential data are documented;

(c) The qualifications of the investigator and research staff, as evidenced by:

(1) Training and previous research, including prior publications; and

(2) An affiliation with a university, private research organization, medical center, state agency, or other qualified institutional entity.

(d) No other state or federal law or regulation prohibits release of the requested information.

* * * * *

Section 10. Enforcement.

Violations of data submission requirements, confidentiality requirements, data use limitations or any other provisions of this rule shall be subject to sanction by the Commissioner as set out in 18 V.S.A. § 9410 in addition to any other powers granted to the Commissioner to investigate, subpoena, fine or seek other legal or equitable remedies.

* * * * *

Supreme Court, U.S.
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No. 14-181

In The
Supreme Court of the United States

ALFRED GOBEILLE, in his official capacity as chair of the VERMONT GREEN MOUNTAIN CARE BOARD,
Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,
Respondent.

On Writ of Certiorari To The
United States Court of Appeals
For The Second Circuit

BRIEF AMICI CURIAE OF AARP, FAMILIES USA, AND U.S. PUBLIC INTEREST RESEARCH GROUP IN SUPPORT OF PETITIONER

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INTEREST OF AMICI CURIAE[1]

AARP is a nonprofit, nonpartisan organization with a membership that strengthens communities and fights for the issues that matter most to families such as health care, employment, income security, retirement planning, affordable utilities and protection from financial abuse. Since its founding in 1958, AARP has advocated for affordable and accessible health care as well as for controlling its costs without compromising quality. In its efforts to foster the health and economic security of individuals as they age, and in response to the growing number of older people who lacked health care services or faced financial burdens due to unaffordable and inaccessible insurance and other health care costs, AARP has sought legislative reforms – both in state legislatures and Congress – to lower costs and increase the quality of health care. To these ends, AARP supports reforms that aim to, among other things, lower drug and health costs, lower the incidence of fraud and waste, assess health system performance, adopt effective health information technology, develop methods for aligning payment

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[1] Pursuant to Supreme Court Rule 37, counsel of record received timely notice of the intent to file this brief and, on behalf of the parties, have consented to the filing of this brief. No counsel for a party authored this brief, in whole or in part; and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No party other than amicus or its counsel made a monetary contribution to its preparation or submission. Letters from the parties consenting to the filing of amicus briefs have been filed with the Clerk of the Court.

incentives with quality and reduced costs, and promote innovative service delivery systems. Lower health care costs and higher quality health care not only benefit individuals, but also serves businesses, and governments.

Families USA, a leading national voice for health care consumers, is dedicated to the achievement of high-quality, affordable health care for all. It is a non-profit, non-partisan organization located in Washington, DC. Families USA advances its mission through public policy analysis, advocacy, and collaboration with partner organizations to promote a patient-and community-centered health system. It provides technical policy assistance to advocates at the state and federal levels to promote and advance value-based payment and delivery of health care, evidence-based medicine that links quality metrics to costs, and price transparency.

U.S. PIRG, the federation of state Public Interest Research Groups ("PIRGs"), is a non-profit, non-partisan advocacy organization that works on behalf of American consumers through public outreach to advocate for policies and strategies to advance the public interest, including bringing down the high cost of health care. U.S. PIRG's mission is to deliver results-oriented public interest activism that protects consumers, encourages a fair, sustainable economy, and fosters responsive, democratic government. U.S. PIRG regularly advocates before state and federal regulators and legislators on issues of health care transparency and cost containment. U.S. PIRG has participated as

amicus curiae in numerous cases involving health care and prescription drug costs.

As part of its health care reform efforts, Vermont requires all entities that pay for health care to provide claims data in order to build a comprehensive all-payer claims database to better assess health care spending, service, quality, and access. Many other states have implemented all-payer claims databases as well. The data collected is used to better inform the public, policymakers, and regulators and influence necessary health care system changes. Amici support efforts to study payer data that are designed to improve health care quality and delivery and lower costs.

Amici's members and other participants and beneficiaries in private, employer-sponsored employee benefit plans rely on the Employee Retirement Income Security Act (ERISA) to protect their rights under those plans.[2] 29 U.S.C. § 1001 *et seq*. Unfortunately, contrary to ERISA's purpose, a statute that was designed to safeguard employee benefits has too frequently been used to deprive employees of rights and protections they previously

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[2] As part of its advocacy efforts to ensure, to the greatest extent possible, that participants and beneficiaries receive the benefit of ERISA's protections, AARP has participated as amicus curiae in numerous cases involving the breadth of ERISA's preemption clause. *See, e.g., Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002); *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001); *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999); *Boggs v. Boggs*, 520 U.S. 833 (1997); *Cal. Div. of Labor Standards Enf't v. Dillingham Constr., N.A.*, 519 U.S. 316 (1997); *John Hancock Mut. Life Ins. Co. v. Harris Tr. & Sav. Bank*, 510 U.S. 86 (1993).

enjoyed under state law. Attempts to use ERISA to undercut health care regulation are contrary to this Court's recognition that such regulation is a traditional area of State concern. *See generally N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.* (*Travelers*), 514 U.S. 645, 654-55 (1995); *Boyle v. Anderson*, 68 F.3d 1093, 1102 (8th Cir. 1995) (ERISA preemption challenge to MinnesotaCare health reforms).

The Court's decision in this case will bear directly on the ability of working Americans to obtain the information they need to evaluate health care options as well as states' ability to provide better consumer protections, higher quality health care, and more affordable health care for their citizens. Thus, the decision here will have a direct and vital bearing on the health and economic security of millions of American consumers, including AARP's members and other older Americans. In light of the significance of the issues presented by this case, amici respectfully submit this brief to facilitate a full consideration by the Court of these issues.

SUMMARY OF ARGUMENT

Vermont – like thirteen other states – requires all entities that pay for health care to provide claims data in order to build a comprehensive all-payer claims database to better assess health care spending, service, quality, and access. Vt. Stat. Ann. tit. 18 § 9410(a)(2)(A) (App. 93). The data collected is used to better inform the public, policymakers, and regulators and influence necessary health care

system changes. *Id.* Transparency in health care cost, quality, and utilization information to the consuming public is important so that they can make informed choices about doctors, hospitals, drugs, health insurance, and other health care services, before they purchase these services – especially since price is not necessarily correlated with quality. *See* Nicolaus Henke et al., *Transparency – the most powerful driver of health care improvement?*, 2011 HEALTH INT'L 65, 72-73 (2011). Indeed, transparency may be the most important precondition to improving quality and reducing costs in the health care system. *Id.*

In contrast to the Vermont law, the general objectives of ERISA are to protect participants and beneficiaries and to ensure that they obtain the plan benefits to which they are entitled. *See* ERISA § 2(b), 29 U.S.C. § 1001(b). One of the methods that Congress devised to achieve that goal was a robust disclosure structure so that individuals would know exactly where they stood with respect to their plan – the benefits to which they are entitled, the circumstances which may preclude them from obtaining those benefits, the procedures necessary to obtain benefits, and who is responsible for managing the plan's assets. S. Rep. No. 93-127 (1974), *as reprinted in* 1974 U.S.C.C.A.N. 4838, 4863; H.R. Rep. No. 93-533 (1974), *as reprinted in* 1974 U.S.C.C.A.N. 4639, 4642, 4649.

ERISA expressly preempts "any and all State laws insofar as they relate to any employee benefit plan." ERISA § 514(a), 29 U.S.C. § 1144(a). The

Court must, therefore, determine whether Vermont's all-payer claims database enabling statute is one of such laws that "relates to any employee benefit plan" – in other words, did Congress intend to preempt this type of state law. *Cipollone v. Liggett Grp., Inc.*, 505 U.S. 504, 516 (1992).

In determining the intended scope of ERISA preemption, the Court has frequently used the traditional preemption analytical frameworks of conflict preemption and field preemption. *See John Hancock Mut. Life Ins. Co. v. Harris Tr. & Sav. Bank*, 510 U.S. 86, 99 (1993) ("[W]e discern no solid basis for believing that, Congress, when it designed ERISA, intended fundamentally to alter traditional preemption analysis."). Indeed, the Court has explicitly adopted the traditional preemption presumption that "the historic police powers of the States" are not superseded "unless that was the clear and manifest purpose of Congress." *Travelers*, 514 U.S. at 655, 661 ("nothing in the language of ERISA or the history of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern."); *Cal. Div. of Labor Standards Enf't v. Dillingham Constr.*, 519 U.S. 316, 331 (1997) (there must be an "indication in ERISA . . . [or] its legislative history of any intent on the part of Congress to pre-empt" a traditionally state-regulated area of law). To overcome this presumption, the Court must determine that the actual operation of the challenged state statute greatly impacts employee benefit plans. *See Dillingham*, 519 U.S. at 324-25.

ERISA's reporting structure works to police the behavior of plan administrators and fiduciaries and ensure participants receive the benefits to which they are entitled. In contrast, the Vermont all-payer claims reporting structure works to influence the future behavior of health care market players. Hence, the Vermont law is clearly not the type of state health care regulation that Congress intended ERISA to preempt and the presumption against preemption has not been overcome. *Travelers*, 514 U.S. at 655, 661.

ARGUMENT

I. ALL-PAYER CLAIMS DATABASES HELP CONSUMERS BY COLLECTING DATA THAT IS USED TO PROMOTE COST TRANSPARENCY AND LOWER HEALTH CARE COSTS.

The United States is the second highest health care spender in the world, with health care costs representing 17 percent of its GDP. *See* The World Bank, *Health Expenditure, Total (percent of GDP) 2013*, http://goo.gl/pG3IDT (last visited Sept. 1, 2015) (data compiled from the World Health Organization's Global Health Expenditure Database). Yet, the cost of health care in the U.S. does not correlate with the quality of that care. Research shows that nations that spend less on health care than the United States have a healthier populace and better quality health care. *See* Karen Davis et al., *Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally*, The Commonwealth Fund

(June 16, 2014), http://goo.gl/UTUecw. Moreover, the rate of health care spending in the U.S. is projected to grow to almost 20 percent of GDP by 2024. Ctrs. for Medicare & Medicaid Servs., *National Health Expenditures 2014-2024 – Forecast Summary*, https://goo.gl/zg3X9R (last visited Sept. 1, 2015). For these reasons, many Americans have long been concerned about and desire to arrest the continually rising cost of health care.

Though the primary purpose of the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), was to make health insurance more affordable for those with little or no coverage, it also included provisions designed to reduce the overall cost of health care. *See* Robert Wood Johnson Found., *How Does the Affordable Care Act Attempt to Control Health Care Costs?* (July 2011), http://www.rwjf.org/en/library/research/2011/07/how-does-the-affordable-care-act-attempt-to-control-health-care-.html (noting that policymakers disagree about just how much these reforms will reduce health care costs). Recognizing that there are myriad methods to achieve health care savings, many states began attempts to control health care costs via different mechanisms even before the ACA was passed. *E.g.*, *Boyle v. Anderson*, 68 F.3d 1093, 1097 (8th Cir. 1995). One such mechanism is to collect from all health care providers information about paid health care claims, and to use that information to develop policies that reduce costs and improve quality. Fourteen states including Vermont require the establishment of such health claims databases; two other states have launched voluntary databases.

See Interactive State Report Map, APCD Council, http://www.apcdcouncil.org/state/map (last visited Sept. 1, 2015). The ACA acknowledges the potential cost-reducing benefits of these databases and thus encourages their use.[3] These databases, known as "all-payer claims databases," have been a useful tool for state regulators and consumers, but their utility is limited if not all payer information is reported.

A. The Purposes Of Vermont's All-Payer Claims Database – To Ensure Quality And Affordable Health Care Services For Its Citizens – May Not Be Fully Realized If Self-Insured Payers Do Not Comply With Its Reporting Requirements.

Similar to the thirteen other states which have established all-payer claims databases, the data collected in Vermont's all-payer claims database are used to: assess existing health care resources, identify health care needs and inform health care policy, evaluate the effectiveness of programs

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[3] The ACA established the Center for Medicare and Medicaid Innovation (CMI) for the purpose of "test[ing] innovative payment and service delivery models to reduce program expenditures . " 42 U.S.C. § 1315a(a)(1). Among the models from which the CMI shall choose to test are models "[a]llowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State ...." *Id.* § 1315a(b)(2)(B)(xi). It is not surprising that states have chosen to establish their own all-payer claims databases given that individual state health care markets are different than the national market. *See generally* Jonathan Skinner, *Causes and Consequences of Regional Variations in Healthcare*, *in* HANDBOOK OF HEALTH ECON. (2012).

designed to improve patient outcomes, compare costs between treatment settings and approaches, provide information to consumers of health care, and improve the quality and affordability of health care services and insurance. *See* Vt. Stat. Ann. tit. 18 § 9410(a)(1)(A)-(F) (App. 92). The state must have accurate information about the health care market in order to achieve these goals.

The free market system is efficient at setting fair and accurate prices only when certain conditions are present. One of those key conditions is information about the price of services and products. In our health care system, however, consumers lack information about the comparative price of health care services and health insurance. *See* Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AMER. ECON. REV. 941, 944 (Dec. 1963) (making the case that the free market economic model for efficiency cannot be applied to the health care market because it lacks several key conditions). Without this information, consumers and regulators cannot know if health care services are offered at a fair price, and whether and what type of regulation is needed to protect consumers in a market that heavily favors the seller. Vermont's all-payer claims database is designed to fill this information gap.

B. Vermont's All-Payer Claims Database Helps Consumers By Giving The State Opportunities To Study The Health Care System And Develop Ways To Reduce Health Care Costs.

Vermont's all-payer claims database allows state regulators, state agencies, contractors, and academic researchers to conduct population-based analyses of the health care system, including analyses of health care access, spending, utilization, and quality. *See* Green Mountain Care Bd., *2015 Annual Report to the General Assembly* 1, 16, http://goo.gl/IUU5xB (last visited Sept. 1, 2015). The data collected in the all-payer claims database has been used, for example, by the Vermont Blueprint for Health program in the Department of Vermont Health Access to inform the development of a statewide health service model. *See* Vt. Blueprint for Health, *2014 Annual Report* 1, 53 (July 31, 2015), http://goo.gl/sHTr08. The Blueprint evaluates a wide range of health care system data to make policy recommendations regarding provider networks, payment modifications, health care delivery models, recognized best practices, health outcomes, health information technology, and myriad other health care issues that can only be fully evaluated with robust data. *Id.* at 4-6.

Vermont's all-payer claims data has been used to study the health care spending growth drivers so that policy makers may be better equipped to develop strategies to slow it down. *See* Truven Health

Analytics, Brandeis University, *Vermont Health Spending Growth Drivers Commercial and Medicaid, 2008-2012*, Presentation to the Green Mountain Care Board (Apr. 16, 2015), http://goo.gl/613wiC. This data has also been used to study the utilization and cost of health care for Vermonters with employer sponsored insurance, *see* Health Care Cost Inst., *2007-2011 Vermont Health Care Cost and Utilization Report* (Dec. 2014), http://goo.gl/uwvgKg, and to report to the public, taxes paid by health insurers on all claims paid. *See, e.g.*, Annual Paid Claims and Enrollment Report 2014, http://goo.gl/DtbkzA (last visited Sept. 1, 2015). The all-payer claims data has been useful for a number of analyses and reports that help the consumer by keeping lawmakers and policy makers well informed of health care system trends. *See generally*, Green Mountain Care Bd., *VHCURES Analytics & Reports*, http://www.gmcboard.vermont.gov/VHCURES/Analytics_and_Reports (last visited Sept. 1, 2015).

C. Transparency In The Health Care System Is Of Paramount Importance To Consumers And To All Stakeholder Efforts To Improve System Value And Performance.

In addition to using the Vermont all-payer claims database to study the health care system, inform policy and regulation, and develop cost containment strategies, the enabling legislation provides transparency for the consumer by mandating that the program:

> [S]hall include a consumer health care price and quality information system designed to make available to consumers transparent health care price information, quality information, and such other information as the Board determines is necessary to empower individuals, including uninsured individuals, to make economically sound and medically appropriate decisions.

Vt. Stat. Ann. tit. 18 § 9410(a)(2)(A) (App. 93).

To this end, the enabling legislation states that the data collected from all payers "shall be available as a resource for insurers, employers, providers, purchasers of health care, and State agencies to continuously review health care utilization, expenditures, and performance." *Id.* § 9410(h)(3)(B). The implementing regulations set out procedures and parameters for classification and release of data for public use. *See* Regulation H-2008-01, 12-040-021 Vt. Code R. §§ 8-9.

The value of transparency in health care cost, quality, and utilization information to the consuming public cannot be overstated. Patients usually do not know the price of health care until after they have received it and price is often not a good indicator for quality. Consumers, therefore, need information to make informed choices about doctors, hospitals, drugs, health insurance, and other health care services, before they purchase these services – just as

they would to make any other major purchase. They also need to know the quality of the services they are receiving and whether they are getting the best value for their dollar. In turn, providers and insurers can use this information, and consumers' feedback, shown through choice, to determine what needs improvement. Indeed, transparency may be the most important precondition to improving quality and reducing costs in the health care system. *See* Nicolaus Henke et al., *Transparency – the most powerful driver of health care improvement?*, 2011 HEALTH INT'L 65, 72-73 (2011) (noting that one study estimated that the United States health care system could realize $300 billion in savings by utilizing health care data to, for example, spot disease trends, improve supply chains, and anticipate the demand for future services).

II. THE MAIN PURPOSE OF ERISA'S DISCLOSURE REQUIREMENTS IS TO ARM PLAN PARTICIPANTS WITH SPECIFIC KNOWLEDGE OF THEIR RIGHTS AND REMEDIES WITH RESPECT TO THEIR PLANS.

A. ERISA's Legislative History Reveals That Congress's Rationale For The Disclosure Structure That It Ultimately Enacted Was To Provide Participants With Comprehensive Information About Their Plans And Plan Administration.

ERISA's relevant legislative history illuminates Congress's reasons for mandating full disclosure to and for the benefit of participants. Congress's purpose in enacting the ERISA disclosure provisions allow:

> the individual participant [to] know[] exactly where he stands with respect to the plan – what benefits he may be entitled to, what circumstances may preclude him from obtaining benefits, what procedures he must follow to obtain benefits, and who are the persons to whom the management and investment of his plan funds have been entrusted.

S. Rep. No. 93-127 (1974), *as reprinted in* 1974 U.S.C.C.A.N. 4838, 4863; H.R. Rep. No. 93-533

(1974), *as reprinted in* 1974 U.S.C.C.A.N. 4639, 4642, 4649; *accord Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 118 (1989). Undeniably, Congress's intent in establishing ERISA's reporting and disclosure provisions was to increase the scope and detail of information and data available to participants. *See Firestone*, 489 U.S. at 118.

A look at the Welfare and Pension Plans Disclosure Act of 1958 (WPPDA), Pub. L. No. 85-836, 72 Stat. 997, the precursor to ERISA, aids in a proper understanding of ERISA. *See* 2A *Sutherland Statutes and Statutory Construction* § 48.03 (7th ed. 2007) (court should consider development of statutory scheme over time "including prior statutes on the same subject"). The 1958 Act required disclosure only of "a description of the plan" and "an annual financial report." 72 Stat. at 999 (§ 5(a)). Congress amended the WPPDA in 1962 to provide for more effective sanctions for violations, impose more detailed disclosure duties, and require plan administrators to retain supporting documentation. Pub. L. No. 87-420, 76 Stat. 35. Congress ultimately determined that even these measures were ineffective to adequately protect the rights of employees. Finding that the WPPDA was "weak in its limited disclosure requirements," and "inadequate" in "protecting rights and benefits due to workers," H.R. Rep. No. 93-533 (1974), *as reprinted in* 1974 U.S.C.C.A.N. 4639, 4642, Congress enacted broader disclosure requirements in ERISA, noting:

> It was expected [under the WPPDA] that the information disclosed would

> enable employees to police their plans. But experience has shown that the limited data available under the [WPPDA] is insufficient. Changes are therefore required to increase the information and data required in the reports both in scope and detail. Experience has also demonstrated a need for a more particularized form of reporting so that the individual participant knows exactly where he stands with respect to the plan. . . . The safeguarding effect of the fiduciary responsibility section will operate efficiently only if fiduciaries are aware that the details of their dealings will be open to inspection, and that individual participants and beneficiaries will be armed with enough information to enforce their own rights as well as the obligations owed by the fiduciary to the plan in general.

Id. at 11.

Congress intended participants to be full partners with the Secretary of Labor to enforce the statute. In order to police their plans and vindicate their rights, participants must have the ability both to obtain needed information, S. Rep. No. 93-127 (1974), *as reprinted in* 1974 U.S.C.C.A.N. 4838, 4863, as well as the right to bring suit for benefits owed to them and fiduciary breaches. ERISA § 502(a)(1)(B),

(a)(2), 29 U.S.C. § 1132(a)(1)(B), (a)(2). ERISA's disclosure requirements thus serve to reinforce ERISA's fiduciary duties by requiring transparency of the fiduciary's actions – both in determining eligibility and the amount of benefits and investment of plan assets. H.R. Rep. No. 93-533, at 11 (1974), *as reprinted in* 1974 U.S.C.C.A.N. 4639, 4649.

B. ERISA's Statutory Structure Demonstrates That Plan Disclosure Was Intended As A Tool For Participants To Police The Administration Of Their Plan And Protect Their Benefits.

The general objectives of ERISA are to protect participants and beneficiaries and to ensure that they obtain the plan benefits to which they are entitled. *See Boggs v. Boggs*, 520 U.S. 833, 845 (1997); ERISA § 2(b), 29 U.S.C. § 1001(b). In its findings and declaration of policy, Congress stated that due "to the lack of employee information and adequate safeguards concerning" the operation of employee plans, it was "requiring the disclosure and reporting to participants and beneficiaries of financial and other information" "with respect to the establishment, operation and administration of such plans." ERISA § 2(a), (b), 29 U.S.C. § 1001(a), (b). ERISA's disclosure and reporting structure gives effect to this purpose.

Congress mandated that basic information concerning participants' rights – that is, summaries of the plan document and the annual report, written

in easily understandable language – must be disclosed to all plan participants automatically. ERISA §§ 101(a), 102(a)(1), 104(b)(1), 104(b)(3), 29 U.S.C. §§ 1021(a), 1022(a)(1), 1024(b)(1), 1024(b)(3). Additional automatic disclosures depend on the type of plan at issue. *See generally* ABA Section of Labor and Emp't Law, *Reporting and Disclosure*, *in* EMPLOYEE BENEFITS LAW, 4-26, 51-54 (Jeffrey Lewis et al. eds., 3d ed. 2012) (detailing different disclosures for pension and welfare plans). Furthermore, Congress decided that the plan must disclose to the participant other specified documents – the plan document itself, the collective bargaining agreement, trust agreement, annual, and any terminal report plans – upon a participant's written request. ERISA § 104(b)(4), 29 U.S.C. § 1024(b)(4). Another method of disclosure is inspection of governing plan documents at the plan administrator's "principal office" and other designated locations. *See* ERISA § 104(b)(2), 29 U.S.C. § 1024(b)(2). Plan administrators have a fiduciary responsibility to administer the plan in accordance with the governing plan documents. ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D).

Congress also mandated filings with the government in order to determine plan compliance with the labor and tax provisions of ERISA. All ERISA covered plans – retirement, health and other types of welfare plans – are required to file an annual report. ERISA § 103(a)(1)(A), 29 U.S.C. § 1023(a)(1)(A). This annual report provides the government with significant information about the plan's finances, investments and actuarial

assumptions. It also includes information on funding policies, description of liabilities, and tax rulings and determination letters. ERISA § 103, 29 U.S.C. § 1023. All of the information filed in the annual report is available to the public for inspection, I.R.C. § 6104(b); ERISA §§ 104(a)(1), 106, 29 U.S.C. §§ 1024(a)(1), 1026.

III. ERISA DOES NOT PREEMPT THE REPORTING REQUIREMENTS OF VERMONT'S ALL-PAYER CLAIMS DATABASE STATUTE.

The Supremacy Clause provides that "the Laws of the United States" (as well as treaties and the Constitution itself) "shall be the supreme Law of the Land . . . any Thing in the Constitution or Laws of any state to the Contrary notwithstanding." U.S. Const. art. VI, cl. 2. Accordingly, under this principle, Congress has the power to enact federal laws that preempt state laws. *See Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 372 (2000). It may do so through express statutory language or implicitly. *See Sprietsma v. Mercury Marine*, 537 U.S. 51, 64 (2002). ERISA contains language that expressly preempts "any and all State laws insofar as they relate to any employee benefit plan." ERISA § 514(a), 29 U.S.C. § 1144(a). The Court must therefore determine whether Vermont's all-payer claims database enabling statute is one of such laws that "relates to any employee benefit plan" – in other words, did Congress intend to preempt this type of state law.

In determining whether there is Congressional intent to supersede state laws, the Court has stressed that the "historic police powers of the States" are not superseded "unless that was the clear and manifest purpose of Congress." *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947); *accord Arizona v. United States*, 567 U.S. ___, ___, 132 S. Ct. 2492, 2500 (2012). The Court has always recognized the careful balance between federalism and states' power and authority to protect their citizens. Accordingly, the Court has identified that "'the purpose of Congress is the ultimate touchstone' of pre-emption analysis." *Cipollone v. Liggett Grp., Inc.*, 505 U.S. 504, 516 (1992) (quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978)); *see* U.S. Const. art. VI, cl. 2.

A. The Court Has Looked To Traditional Preemption Concepts To Determine The Reach of ERISA's Preemption Clause.

In its search to better define the parameters of the "relates to" portion of ERISA's express preemption clause,[4] and to ascertain Congress's intent to preempt state law, the Court has revisited the traditional preemption analytical frameworks of conflict preemption and field preemption. *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co. (Travelers)*, 514 U.S. 645, 654-55 (1995); *Cal. Div. of Labor Standards Enf't v. Dillingham Constr.*

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[4] ERISA § 514(a), 29 U.S.C. § 1144(a), provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . ."

(*Dillingham*), 519 U.S. 316 (1997); *accord John Hancock Mut. Life Ins. Co. v. Harris Tr. & Sav. Bank*, 510 U.S. 86, 99 (1993) ("[W]e discern no solid basis for believing that, Congress, when it designed ERISA, intended fundamentally to alter traditional preemption analysis."); *Egelhoff v. Egelhoff*, 532 U.S. 141, 152–53 (2001) (Scalia, J., concurring) (normal field and conflict preemption principles should be applied in place of "relates to" test). Under conflict preemption, if "compliance with both state and federal law is impossible" or if "the state law 'stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress,'" then the state law is preempted. *California v. ARC America Corp.*, 490 U.S. 93, 100-101 (1989) (quoting *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941)); *accord Travelers*, 514 U.S. at 654. Under field preemption, a court can determine that Congress intended to totally displace state law by inferring from a framework of regulation "so pervasive...that Congress left no room for the States to supplement it" or where there is a "federal interest...so dominant that the federal system will be assumed to preclude enforcement of state laws on the same subject." *Rice*, 331 U.S. at 230. In either situation, federal law must prevail. *Accord Oneok, Inc. v. Learjet, Inc.*, 135 S. Ct. 1591, 1594 (2015); *Arizona*, 132 S. Ct. at 2502. Accordingly, in its ERISA preemption analysis, the Court has adopted the long-established presumption that "the historic police powers of the States" are not superseded "unless that was the clear and manifest purpose of Congress." *Travelers*, 514 U.S. at 655 (quoting *Rice*, 331 U.S. at 230). *Dillingham* reaffirmed this statement by holding that there must

be an "indication in ERISA . . . [or] its legislative history of any intent on the part of Congress to pre-empt" a traditionally state-regulated area of law. 519 U.S. at 331.

B. The Court Has Recognized That ERISA Was Not Intended To Invade The States' Traditional Power To Regulate Health Care.

State or local governments have several reasons to assert their police powers to enact programs to ensure that their citizens have affordable, quality health coverage: to improve the quality and life expectancy for individual citizens; to stabilize the labor pool and maintain productivity in the business community; to maintain and increase access to health care facilities and other resources; and to promote the general well-being of the community at large. *See* Karen Davis, The Commonwealth Fund, *The Costs and Consequences of Being Uninsured*, MED. CARE RES. AND REV. 60 (2) (June 2003), http://goo.gl/A4CXTL. The power of state and local governments to enact laws designed to ensure the health and welfare of the state's residents and workers is well-established and within the traditional police power of state and local governments. *See Sherlock v. Alling*, 93 U.S. 99, 103 (1876) (states' traditional role to regulate "subjects relating to the health, life, and safety of their citizens"); *Huron Portland Cement Co. v. City of Detroit*, 362 U.S. 440, 442 (1960) ("promoting the health and welfare of the city's inhabitants . . . clearly falls within the exercise of even the most

traditional concept of what is compendiously known as the police power").

Indeed, the well-settled authority of states to regulate in certain areas has evolved into a presumption that, when federal laws overlap with areas traditionally within the local police power, both local and federal law may have concurrent application. *See Pacific Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm'n*, 461 U.S. 190, 205 (1983); *Huron Portland Cement Co.*, 362 U.S. at 442. In *Pacific Gas*, the Court rejected the contention that a federal law concerning the regulation of new nuclear power plants preempted state regulation of "all things nuclear," explaining "the States retain their traditional responsibility in the field of regulating electrical utilities for determining questions of need, reliability, cost, and other related state concerns." 461 U.S. at 205. Thus, federal preemption of one aspect of nuclear power did not preclude state regulation of peripheral matters, within the traditional realm of local police power where the federal law did not clearly intend to displace state law so broadly. Furthermore, *Huron* noted that "[i]n the exercise of [their police power], the states and their instrumentalities may act . . . concurrently with the federal government." 362 U.S. at 442. These decisions demonstrate how crucial it is to analyze the Congressional purpose in enacting the federal statute.

The Court also has conscientiously applied this presumption where the state uses its historic police powers to regulate in matters of health and safety

that are at the heart of the state's authority and obligation to protect its residents. *See Hillsborough Cty. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 715 (1985) (federal blood plasma regulations promulgated by the Food and Drug Administration do not pre-empt county laws imposing additional requirements beyond the federal law). The Court has not treated ERISA otherwise. *E.g.*, *Travelers*, 514 U.S. at 661 (courts "start with the assumption that the historic police powers of the States were not to be superseded by [federal law] unless that was the clear and manifest purpose of Congress"). Accordingly, the Court generally has held that ERISA does not preempt state laws regulating in the health care arena.[5] *See id.* ("nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern."); *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814-15 (1997) (finding state tax on hospitals not preempted because ERISA does not supplant presumption that state law is not preempted); *Dillingham*, 519 U.S. at 325 (prevailing wage statute is within state's traditional power to regulate). "[I]f ERISA were concerned with any state action – such as medical-care quality standards or hospital workplace regulations – that increased costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we could

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[5] Applying the historic presumption in claims of ERISA preemption makes particular sense because health plans were not the main focus of Congress's concern during the enactment of ERISA. *See generally* ABA Section of Labor and Emp't Law, EMPLOYEE BENEFITS LAW. at lxviii-lxix (Jeffrey Lewis et al. eds., 3d ed. 2012).

scarcely see the end of ERISA's pre-emptive reach." *Dillingham*, 519 U.S. at 329; *accord Egelhoff*, 532 U.S. at 147. Consequently, the Vermont all-payer claims database reporting requirements should be treated no differently than these other health care regulations.

C. There Is No Conflict Between ERISA And The Vermont All-Payer Claims Database Reporting Requirement.

Following traditional preemption analysis, the Court in *Boggs* stated that the first question in ERISA preemption analysis is when "state law conflicts with the provisions of ERISA or operates to frustrate its objects." 520 U.S. at 841. The Court further stated that if a court determined that a state law directly conflicted with ERISA's provisions, no further analysis was necessary. Not surprisingly, the Court also recognized that state laws that conflict with the substantive provisions of ERISA obviously "relate to an employee benefit plan." *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985); *accord Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990) (state law conflicts with ERISA § 510).

In *Boggs*, the Court held that ERISA preempts state community property and succession laws insofar as they apply to retirement plans because the state laws directly conflicted with ERISA's provisions regarding spousal rights (*i.e.*, the provision for a joint and survivor form of annuity) and operated to frustrate ERISA's purpose to ensure a stream of

income to surviving spouses. 520 U.S. at 843. Similarly, in *Egelhoff*, the Court found that ERISA preempted a state statute which, upon a person's divorce, caused any previous beneficiary designations of non-probate assets including life insurance policies and employee benefit plans designating the former spouse to be automatically revoked. 532 U.S. at 147-48. The Court stated that this state law directly conflicts with ERISA's requirements that plans be administered, and benefits be paid, in accordance with plan documents. *Id.* at 150. Moreover, laws providing alternate enforcement mechanisms for employees to obtain ERISA plan benefits are preempted because of a direct conflict with ERISA's civil enforcement provisions. *Aetna Health Inc. v. Davila,* 542 U.S. 200, 217-18 (2004); *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 54 (1987).

Applying this conflict preemption analytical framework, there is no question that Vermont's all-payer database reporting requirements do not directly conflict with any ERISA provisions. Compliance with both state and federal law is possible and the state law does not stand as an obstacle to the accomplishment and execution of ERISA's purpose to provide full disclosure to participants concerning the type of benefits, the eligibility for benefits, and the methods to protect those benefits.

D. In Enacting ERISA, Congress Did Not Intend To Preempt State Laws – Like Vermont's All-Payer Claims Database Reporting Requirement – That Regulate Quality And Affordability Of Health Care.

In determining the field of preemption for employee benefit plans, a court must determine that Congress intended to totally displace state law by inferring from a framework of regulation "so pervasive . . . that Congress left no room for the States to supplement it" or where there is a "federal interest . . . so dominant that the federal system will be assumed to preclude enforcement of state laws on the same subject." *Rice*, 331 U.S. at 230. Accordingly, a court must look to "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans." *Dillingham*, 519 U.S. at 325. At bottom, the inquiry is how does the actual operation of the challenged state statute effect employee benefit plans. *See id.* at 324-25; *De Buono*, 520 U.S. at 815.

Here, that examination is revealing. As Congress clearly indicated, *see supra* Part II, ERISA's reporting and disclosure for health plans concern participants' right to, and eligibility for, certain specific benefits as well as the procedures to obtain those benefits. This is so because ERISA's purpose for disclosure is to ensure that participants obtain the benefits they were promised. In addition,

ERISA's reporting and disclosure to participants and the government ensures that fiduciaries administer the plan in line with their fiduciary responsibilities including prudently investing and managing plan assets.

In contrast, the reporting requirements of Vermont's all-payer claims database seek information about the actual utilization, cost, and delivery of health care services so that the State, insurers, providers, policymakers, and consumers, among others, can make data-driven, evidence-based decisions about health care.[6] For example, enabling statute's implementing regulations require payers to report annually whether they have paid claims for Vermont citizens or for citizens of other states that have obtained health care services from Vermont providers. *See* Regulation H-2008-01, 12-040-021 Vt. Code R. § 4.A. If claims have been paid for Vermonters or for care provided in Vermont, payers are required to report detailed information about the claims paid, such as: amount paid, deductible, co-pay, co-insurance, premiums, health care information about the insured, what type of provider rendered services, and in what type of setting the care was provided. *See id.* § 3 (definitions); § 4.D. (listing the

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[6] ERISA was not designed to address health care costs or quality of care; indeed, in the 1970's, these were not on Congress's radar screen because they were not issues in the general economy. Kaiser Family Foundation, *Snapshots: Health Care Spending in the United States & Selected OECD Countries*, Exh. 3, 4A, 4B (Apr 12, 2011), http://kff.org/health-costs/issue-brief/snapshots-health-care-spending-in-the-united-states-selected-oecd-countries/.

types of data that shall be reported); § 5 (Required Health Care Data Files); Apps. C-1, C-2, D-1, D-2, E-1, E-2 (detailing specific data to be reported). Not only is the type of information required by the all payer claims database statue and regulations not of the same type as those required in ERISA disclosures, but it is also not used for the same purpose. All-payer claims data is not used to determine whether beneficiaries received the benefits to which they were entitled, as ERISA disclosures are used. For example, the regulations do not require information about whether claims should have been paid. *See, e.g., id.* § 5.A(5)(8) (denied medical claims are exempted from reporting requirements). Only information about what type of insurance a person was eligible for at the time of reporting is sought. *See id.* Apps. C-1, C-2. ERISA, of course, does not mandate the reporting of costs or utilization of benefits.[7]

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[7] Obviously, ERISA requires reporting and disclosure from employee benefit plans concerning specific information about the plan. This does not mean that all state laws requiring reporting and disclosure from employee benefit plans are automatically preempted by ERISA. Indeed, if the Second Circuit and Respondents are correct, state laws requiring any reporting and disclosure regardless if the plan is operating like any other commercial entity would be preempted. This position would essentially not only overrule *Travelers* and its progeny, but earlier ERISA preemption jurisprudence as well. *E.g., Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Mackey v. Lanier Collection Agency*, 486 U.S. 825, 828-830 (1988). The Court has been much more nuanced in its ERISA preemption analysis – again harkening back to the purposes of ERISA and the effect of the state law on ERISA plans.

This is not a case in which Vermont has mandated employee benefit structures or their administration, *e.g.*, *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125 (1992) (workers' compensation law prohibiting termination of health benefits of workers receiving workers' compensation benefits is preempted), forbidden a method of calculating pension benefits that federal law permits, *e.g.*, *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524-525 (1981) (preempted state law eliminating federally permitted integration of pension benefits with Social Security), or required employers to provide certain benefits. *E.g.*, *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983) (preempted state law requiring the provision of pregnancy benefits); *Metro. Life Ins.*, 471 U.S. at 724 (preempted state law requiring plans to include minimum mental health benefits).

Nor does the Vermont all-payer database reporting requirements bind employers or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as a regulation of an ERISA plan itself. *E.g.*, *Boggs*, 520 U.S. at 841-42; *Egelhoff*, 532 U.S. at 147-48. It contains no provisions that expressly refer to ERISA or ERISA plans. *Mackey v. Lanier Collection Agency*, 486 U.S. 825, 828-830 (1988) (an explicit reference to ERISA in defining the scope of the state law's application is pre-empted); *Greater Washington Bd. of Trade*, 506 U.S. at 130-131 (same). And, Vermont's statute does not provide alternate enforcement mechanisms for employees to obtain ERISA plan benefits. *E.g.*, *Davila*, 542 U.S. at 217-

18; *Dedeaux*, 481 U.S. at 54. *See generally Travelers*, 514 U.S. at 668 (recognizing that laws having direct effects on plans are preempted).

ERISA's reporting structure works to police the behavior of plan administrators and fiduciaries and ensure participants receive the benefits to which they are entitled. The Vermont all-payer claims reporting structure works to influence the future behavior of health care market players. Accordingly, a consideration of the actual operation of the Vermont law demonstrates that while it may impose some burdens on the administration of ERISA plans, it is not the type of state law that Congress intended ERISA to preempt.

CONCLUSION

Though the Court has recognized that health care regulation is an area of traditional state concern, *Travelers*, 514 U.S. at 654-55, there have been ongoing attempts to use ERISA to undercut state efforts to regulate health care. *See, e.g.*, *Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039, 1044-45 (9th Cir. 1998) (ERISA did not preempt health care regulation); *Boyle v. Anderson*, 68 F.3d 1093, 1099 (8th Cir. 1995) (same). Respondent similarly attempts to skirt Vermont's all-payer claims database reporting requirement by incorrectly invoking ERISA preemption. In so doing, Respondent not only advances an incorrect reading of ERISA's preemption clause and interpretive jurisprudence, but also jeopardizes the utility of Vermont's all-payer claims database. Respondent

thus denies consumers the benefits of transparency, choice, reduced costs, and better informed health care policy.

For the above reasons, amici urge the Court to reverse the Second Circuit's decision and hold that ERISA does not preempt Vermont's all-payer database reporting requirements.

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No. 14-181

In the Supreme Court of the United States

ALFRED GOBEILLE, in his official capacity as chair of the Vermont Green Mountain Care Board,
Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,
Respondent.

On Writ Of Certiorari To The United States Court of Appeals for the Second Circuit

BRIEF OF THE AMERICAN BENEFITS COUNCIL, AMERICA'S HEALTH INSURANCE PLANS, THE ERISA INDUSTRY COMMITTEE, THE HR POLICY ASSOCIATION, THE NATIONAL BUSINESS GROUP ON HEALTH, AND THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

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BRIEF OF THE AMERICAN BENEFITS COUNCIL, AMERICA'S HEALTH INSURANCE PLANS, THE ERISA INDUSTRY COMMITTEE, THE HR POLICY ASSOCIATION, THE NATIONAL BUSINESS GROUP ON HEALTH, AND THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

INTEREST OF THE *AMICI CURIAE*[1]

The American Benefits Council (the Council) is a national nonprofit organization dedicated to protecting and fostering privately sponsored employee benefit plans. The Council's approximately 400 members are primarily large multistate U.S. employers that provide employee benefits to active and retired workers and their families. The Council's membership also includes organizations that provide employee benefit services to employers of all sizes. Collectively, the Council's members either directly sponsor or provide services to retirement and health plans covering virtually all Americans who participate in employer-sponsored benefit programs.

America's Health Insurance Plans (AHIP) is the national association representing nearly 1,300 member companies that collectively provide health insurance coverage to more than 200 million Americans. The vast majority of individuals insured by AHIP

[1] Pursuant to Rule 37.6, *amici* affirm that no counsel for a party authored this brief in whole or in part and that no person other than *amici*, their members, and their counsel made a monetary contribution intended to fund its preparation or submission. Counsel of record for the petitioner and the respondent have both filed blanket consents to the filing of *amicus curiae* briefs with the Clerk of this Court.

members are participants in, or beneficiaries of, employee benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001 *et seq.* The association's goal is to provide a unified voice for the health care financing industry, to expand access to high quality, cost-effective health care to all Americans, and to ensure Americans' financial security through robust insurance markets, product flexibility and innovation, and an abundance of consumer choice.

The ERISA Industry Committee (ERIC) is a nonprofit organization representing America's largest employers that maintain ERISA-covered pension, healthcare, disability, and other employee benefit plans. These employers provide benefits to millions of active workers, retired persons, and their families nationwide. For this reason, ERIC frequently participates as *amicus curiae* in cases that have the potential for far-reaching effects on employee benefit plan design or administration.

The HR Policy Association represents the most senior human resource executives in more than 370 of the largest corporations doing business in the United States. Collectively, these companies employ more than ten million employees in the United States, nearly nine percent of the private sector workforce. As America's largest employers, HR Policy Association member companies provide health benefits to employees, retirees, and their dependents that are regulated under ERISA.

The National Business Group on Health (NBGH) is a non-profit organization devoted to representing large employers' perspectives on national health policy issues. With 429 members, NBGH is the national voice of large employers dedicated to finding innova-

tive and forward-thinking solutions to the nation's most important health care issues. NBGH facilitates communications between large employers and national policymakers on key health care issues and participates actively in national health policy debates.

The Chamber of Commerce of the United States of America (the Chamber) is the world's largest business federation, representing an underlying membership of over three million businesses and organizations of every size, in every industry sector, and from every geographic region of the country. An important function of the Chamber is to represent the interests of its members by filing *amicus* briefs in cases involving issues of vital concern to the nation's business community. Many Chamber members provide health benefits to employees and arrange for the provision of health care services through employee welfare benefit plans regulated under ERISA.

INTRODUCTION AND SUMMARY OF ARGUMENT

When Congress enacted ERISA, it wanted to encourage employers to offer benefit programs for their employees. In the case of healthcare benefits, companies could choose either to purchase individual insurance policies, which would be subject to regulation by the States, or to self-fund a nationwide plan, which would be subject to a uniform, federal program of regulation.

This case is about whether a company that has elected to create a self-funded plan for the exclusive purpose of providing healthcare benefits to its employees and their families—a plan that, under ERISA, is subject to uniform federal regulation—

may nevertheless be forced by the States to function as a clearinghouse for state data-collection efforts. The Court's answer to this question has important implications not only for self-funded employer health plans, but for all other employer benefit plans. The more States are empowered to impose burdensome regulatory requirements on employers, the more they will do so. This slippery slope presents a serious threat to the viability of welfare benefit plans, and thus to the purposes of ERISA.

State programs such as Vermont's all-payer claims database (APCD) undercut ERISA's objectives by subjecting self-funded plans to a morass of state reporting requirements that Congress neither intended nor allowed in enacting ERISA.

A.

Self-funded employer plans provide medical benefits to some 93 million Americans. Employers large and small rely on such plans because of the benefits of self-funding, which include flexibility in fashioning benefits to suit an employer's workforce; the ability to pay claims after they are incurred, instead of prepaying insurance premiums; and reductions in regulatory burdens and administrative costs.

The advantages of self-funding inure not only to benefit employers, but to participants in those employers' health insurance plans. To put it simply, an employer that can reduce the costs of administering benefit plans can provide more generous benefits to its employees. Congress sought through ERISA to encourage employers to establish self-funded plans, so that more plans and plan participants would reap the benefits of self-funding.

B.

Laws that require self-funded employer plans to report data on medical claims to state APCDs impose considerable compliance burdens on plans. Plan costs necessarily increase, and Congress's plan for uniform regulation is compromised notwithstanding its essential role in the passage of the Act. No two state APCDs are the same; each requires that a plan (or its agent) report somewhat different data, concerning differently defined patient populations, at different times, and in different file formats. A plan operating in multiple states would need to devote substantial time and resources to navigating this complex web of regulations—resources that Congress intended should be spent on paying benefits to plan participants. APCD laws thus have an impermissible effect on self-funded employer plans and are expressly preempted by ERISA. See 29 U.S.C. § 1144(a). Petitioner touts the fact that, under the peculiar circumstances of this case, it is technically the employer's third-party administrator that must comply with Vermont's APCD law. That is immaterial, however, for it cannot be the case that Congress intended to protect sponsors from piecemeal regulation but to expose their plans to a different regime of burdensome requirements if they choose to use a third-party administrator.

C.

APCD laws also frustrate one of ERISA's core mandates: that plans must be operated *solely* for the purpose of paying benefits to plan participants. APCD laws contemplate that plans will serve an entirely different purpose—namely, collecting participants' medical data to support state programs and initiatives. Commandeering ERISA plans for that

use, or the other infinite possibilities of state use that await on the horizon, necessarily undermines the objectives of ERISA and the goals that Congress sought to achieve through the statute. Vermont's APCD law expands the purpose and function of benefit plans contrary to ERISA's dictates, and is therefore preempted.

ARGUMENT

Using self-funded welfare benefit plans as data clearinghouses is incompatible with ERISA.

State APCDs impose real burdens on self-funded plans. Those plans that operate across state lines are subject to onerous requirements that require plan sponsors or their agents to develop state-by-state data-collection systems and reporting mechanisms. APCD laws disrupt the uniform regulatory scheme that Congress sought to create for employer benefit plans and frustrate Congress's desire that ERISA plans' resources be used efficiently to pay benefits and plan expenses. ERISA preempts state laws that so directly interfere with Congress's design. Thus, this Court should affirm the judgment below.

A. SELF-FUNDED EMPLOYER PLANS ARE MUTUALLY BENEFICIAL FOR EMPLOYERS AND EMPLOYEES

1. Self-Funded Employer Plans Provide Benefits To Millions Of Americans

An employer can structure the health benefits it provides to its employees in two different ways. The first is for the employer to purchase an insurance policy from an insurance company, paying a premium to the insurance company for every employee

who is covered. This type of plan is referred to as a "fully insured" plan, since the insurance company assumes the full risk of covering employees' medical claims. See Employee Benefit Research Institute, *Health Plan Differences: Fully-Insured vs. Self-Insured* (Feb. 11, 2009), http://www.ebri.org/pdf/FFE114.11Feb09.Final.pdf.

Alternatively, an employer can choose to establish a "self-funded" or "self-insured" plan. An employer with a self-funded plan pays for employees' medical claims out of its own assets and thus bears the entire risk associated with employees' medical claims, although it may purchase a "stop-loss" insurance policy to cover its losses when its aggregate costs grow unexpectedly high. Some employers with self-funded plans—though not all—choose to contract with third-party administrators (TPAs) rather than control the day-to-day operations of their health plans themselves. A typical TPA "administers the health plan by processing the claims, issuing ID cards, handling customer questions and performing other tasks." Cigna White Paper, *Advantages and Myths of Self-Funding* 2 (Feb. 2014), http://www.cigna.com/assets/docs/business/small-employers/841956_b_self_funding_whitepaper_v8.pdf.

Although the fully insured model was the traditional means by which employers provided health insurance benefits to employees, self-funded employer plans are now overwhelmingly prevalent among large and mid-size employers and have become more popular with smaller employers in recent years. Indeed, self-funded employer plans now cover more employees than fully insured plans. A recent survey found that 147 million Americans—"over half of the

non-elderly population"—receive employer-sponsored health benefits. See Henry J. Kaiser Family Foundation, *2015 Employer Health Benefits Survey: Summary of Findings* 1 (Sept. 22, 2015), http://kff.org/report-section/ehbs-2015-summary-of-findings/. Of those individuals, 63%—approximately 93 million—participate in self-funded employer plans, including 94% of workers in firms with at least 5,000 employees. Henry J. Kaiser Family Foundation, *2015 Employer Health Benefits Survey: Section Ten: Plan Funding* (Sept. 22, 2015), http://kff.org/report-section/ehbs-2015-section-ten-plan-funding/. In 2000, by contrast, only 49% of workers participated in self-funded employer plans. *Ibid.*

2. Self-Funded Employer Plans Provide Many Advantages Over Fully Insured Plans

Employers have increasingly turned to self-funded employer plans because, in comparison to fully insured health plans, self-funded employer plans are often more flexible and less expensive. Self-funded employer plans thus improve both employers' bottom lines and the level of benefits that they can provide to their employees.

Self-funded employer plans offer employers and employees four principal advantages over fully insured health plans:

First, *self-funded employer plans give employers—particularly small employers—much more choice as to which benefits their plans will provide.* Employers who opt for a fully insured plan are limited to the insurance policies approved for sale in the state where the employer is located. By contrast, when

employers self-insure, they can customize their plans by tailoring their benefit packages (above and beyond any applicable statutory requirements) to match the needs of their workforce. Cigna White Paper, *supra*, at 3. The ability to customize benefits is especially valuable to smaller businesses, which often have specialized workforces whose needs differ from those of most larger companies. *Ibid.*

Second, *employers who self-fund save money because they do not need to prepay insurance companies for health costs that may never be incurred.* When an employer opts to provide fully insured medical benefits, it pays to an insurer the expected cost of benefits plus a risk premium and also typically owes insurance premium taxes to each State where it does business. By contrast, so long as it can absorb or spread the risks, an employer with a self-funded plan can avoid the risk premium and the premium taxes, and does not need to pay in advance. It can keep the cash used to pay medical expenses in its own reserves, where the money can earn interest for the plan. See The Alliance, *When You're Considering Self-Funding* 3 (Aug. 2014), http://www.the-alliance.org/uploadedFiles/Downloads/WhenYoureConsideringSelfFunding.pdf.

Third, *self-funded plans are typically less expensive to operate than fully insured plans.* Self-funded plans generally have lower administrative costs than fully insured plans. See The Alliance, *supra*, at 4 ("Employers frequently find that administrative costs for a self-funded program through a TPA are lower than those charged by an insurance carrier."). The lower overhead of self-insurance allows more of an employer's resources to be spent on paying benefits to employees and less on plan expenses.

Fourth, *employers offering self-funded plans are not subject to conflicting regulations in each of the states in which they operate.* Fully insured plans are subject to state and local insurance laws and thus must comply with differing mandates in each state (and perhaps every different locality) in which they operate. Self-funded plans, by contrast, are covered by ERISA and subject only to ERISA's regulatory standards. See 29 U.S.C. § 1144(b)(2)(B) (exempting employee benefit plans from state insurance and banking regulations). Thus, self-funded plans are able to streamline their operations by offering one uniform set of benefits everywhere they operate. This lowers plans' administrative costs and ensures that employees who move from place to place but stay with the same employer can enjoy the same benefits no matter where they reside. See The Alliance, *supra*, at 3-4; Cigna White Paper, *supra*, at 3.[2]

Self-funded plans are a win-win proposition for employers and their employees. Self-funding lowers employers' costs by allowing them to retain control over the terms and features of their own benefit plans and enabling them to manage how risks are liquidated. And by lowering employers' costs, self-

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[2] The flexibility of self-funded employer plans also enables them to experiment more easily with innovative, evidence-based benefit designs and then implement those designs on a national scale. For example, recent research has shed considerable light on which treatments for children with autism work better than others. Self-funded employer plans can easily adapt their nationwide benefit packages to reflect these new findings. See P. Rich & D. Landers-Nelson, National Business Group on Health, *Benefit Manager Guide: Therapies for Children with Autism Spectrum Disorder* (Oct. 2014) (excerpted summary for public).

funding helps plan beneficiaries, who enjoy greater benefits than they otherwise would. One of the principal goals of ERISA is to ensure that sponsors and beneficiaries can experience the benefits of uniform federal regulation.

B. APCD STATUTES LIKE VERMONT'S IMPOSE A SUBSTANTIAL AND UNWARRANTED BURDEN ON SELF-FUNDED EMPLOYER PLANS

Vermont and many other states require self-funded employer plans to report data on participants' medical claims to state-run "all-payer claims databases," or APCDs. Each of these States requires that different data be reported in a different format and on a different schedule, meaning that an employer that offers a health benefit plan in more than one State is potentially subject to a complex web of regulations. Complying with these varied data-reporting requirements is a costly and burdensome undertaking for self-funded employer plans. If forced to comply with the dizzying array of APCD requirements, self-funded employer plans would be required either to dedicate personnel to the task of mastering and satisfying the various requirements or to pay outside parties to do the same. Either approach obviously diverts resources away from the payment of benefits to plan participants. Congress enacted ERISA precisely to protect plans from this sort of overwhelming regulatory burden.

1. An Increasing Number Of States Are Adopting Mandatory APCD Laws, Many Of Which Have Conflicting Requirements

Though APCDs are a relatively new phenomenon, they are proliferating rapidly across the coun-

try. Since 2003, when Maine established the first APCD in the United States, twenty other states have created their own APCDs. Eighteen of these twenty-one state databases are "mandatory" APCDs that require all payers of medical claims—including self-funded health benefit plans—to report data on their customers or plan participants. See N.Y. Br. 4-5.

Thus, a large number of states already purport to subject self-funded plans that operate nationally to claims reporting requirements. And that number is likely to increase in the near future: *nineteen* additional states are either considering legislation that would create a mandatory APCD or are otherwise exploring the idea. NY. Br. 5.

Although state APCDs share certain features in common, each State's database is distinctive. States calibrate the features of their APCDs to match their idiosyncratic policy goals, creating significant differences between each database's requirements. To cite only a few examples of these differences:

a. *Different APCDs require different claims to be reported.* The coverage of each state APCD's reporting requirement varies because states do not take the same approach in determining which claims are subject to reporting. Vermont, for example, requires reporting of all medical care that is provided to Vermont residents *and* all care provided within the State of Vermont (even to nonresidents). Vt. Dep't of Banking, Ins., Secs. & Health Care Admin., Regulation H-2008-01, § 4(D). Rhode Island, by contrast, requires reporting only of care provided to Rhode Island residents; care provided in the state to nonresidents is not covered. See R.I. Dep't of Health, Rules and Regulations Pertaining to the Rhode Island All-Payer Claims Database §§ 1.18, 1.20, 4.1(a),

http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7305.pdf.

States also lack a uniform approach to determining who qualifies as a "resident" for APCD reporting purposes. Colorado and Utah, for example, consider students attending in-state colleges to be residents subject to APCD reporting, no matter where they officially reside for other purposes. See Colorado Center for Improving Value in Health Care, Colorado All-Payer Claims Database Data Submission Guide 5, http://www.civhc.org/getmedia/29f43b37-b39d-4373-85f5-1c1232f2d9c7/Data-Submission-Guide-V7-June-2015.pdf.aspx/; Utah Department of Health, Utah All-Payer Claims Database Data Submission Guide 3, http://health.utah.gov/hda/apd/UT%20APCD%20DSG%20v2.1.pdf. Vermont, on the other hand, appears *not* to treat students as residents. See Vt. Regulation H-2008-01, § 4(D).

The States' conflicting requirements as to which claims must be reported and who qualifies as a "resident" mean that many claims may have to be reported to multiple states at once. A claim involving care provided in Vermont to a Rhode Island resident must be reported to both states, for example. An employer plan that operates in more than one state likely must keep track of many such overlapping reporting requirements.

b. *Different APCDs have different schedules for reporting data.* State APCDs do not all require submission of data on the same timetable. On the contrary, at least *four* different reporting schedules are in use by APCDs around the country. Maryland and Oregon require that data be submitted quarterly. But Colorado, Massachusetts, and Tennessee require that data be submitted every month. Maine, New

Hampshire, and Vermont's APCDs take a third approach, requiring that different plans report data at *different* intervals depending on the number of covered lives in the plan. And finally, Minnesota allows reporters simply to choose between monthly and quarterly data reporting. See Washington Office of Financial Management, WA-APCD Rules Background Paper #4: Deadlines for Submission of Claim Files 4-5 (Sept. 2015), http://www.ofm.wa.gov/healthcare/pricetransparency/pdf/paper_4.pdf. Thus, a plan that operates in multiple states would be unable to have one internal schedule for reporting all of its claims data.

c. *Different APCDs require that data be submitted in different formats.* State APCD laws prescribe not only what data must be reported and when, but also what format that data must be in. And here, too, the requirements of each state's APCD vary: different states require that data be submitted in "considerably different data file formats." Al Prysunka, Milliman Healthcare Analytics Blog, *APCDs: Moving Toward Standardization of Data Collection* (Nov. 30, 2012), http://info.medinsight.milliman.com/2012/11/apcds-moving-toward-standardization-of-data-collection/. As a result, employers operating in more than one state must develop different programs and protocols for data submission in each state.

2. Reporting Health Care Claims Data To All The States That Require It Is Burdensome For Self-Funded Employer Plans

The task of reporting medical claims data to state APCDs would be costly and difficult enough for self-funded employer plans if every state's requirements were exactly the same. Collecting health care data for thousands of covered plan members, format-

ting it, and submitting it to an APCD is a time- and labor-intensive undertaking—one that has only become more difficult over time, as state regulators have requested that more and more data points be reported for each claim. Minnesota Community Measurement, *Health Care Data Collection: Exploring the Root Causes of Provider Burden in Minnesota* 1 (2015), http://mncm.org/wp-content/uploads/2015/03/MNCM_WhitePaper_PrvdrBrdn_Final.pdf (noting that due to the proliferation of health quality measures among state regulators, "there is growing concern in the [medical] community that the burden of collecting and submitting data—represented primarily by the cost of additional human resources—is beginning to outweigh the benefits").

Yet the multiplicity of conflicting and overlapping reporting requirements in different states has made the burden on plans even greater. For one thing, self-funded plans that operate in multiple states must deal with the sheer technical challenge of reporting data to numerous states at different times and in different formats. As one prominent technology advocacy group has noted, it is simply "burdensome and costly for plans to set up and secure multiple large data submissions to different entities in various locations, especially if those entities require different data formats." Center for Democracy & Technology, *Decentralizing the Analysis of Health Data* 9 (Mar. 22, 2012), https://cdt.org/files/pdfs/Decentralizing-Analysis-Health-Data.pdf. Indeed, even the strongest proponents of the creation of APCDs acknowledge that the States' varying requirements for data reporting impose a significant technical burden on plans. *See, e.g.*, APCD Council, *Standardization of Data Collection in All-Payer Claims Databases* 1 (Jan. 2011), https://

www.apcdcouncil.org/file/83/download?token=R4vbK7Xf (noting that "each state is collecting different data by different methods and with different definitions," which "rais[es] costs for payers submitting data to the states (especially those payers that are operating in multiple states)"); *id.* at 2 ("As APCDs are required in more states, the cost to payers will become significant."); see also Patrick B. Miller, State Coverage Initiatives, Robert Wood Johnson Foundation, *All-Payer Claims Databases: An Overview for Policymakers* 8 (May 2010), https://www.apcdcouncil.org/publication/all-payer-claims-databases-overview-policymakers (noting that payers who operate in numerous states must "bear the compounded costs of responding to unique state reporting requirements").

In addition to the technical burden of reporting, plans operating in multiple states must invest time and resources in keeping track of each State's requirements, or assuring that a third-party administrator is doing so.[3] Most state APCDs' requirements are spelled out in regulations rather than in statutory law, allowing those requirements to change without the need for legislative action. And in some states, certain changes to APCD regulations can be made without even needing to go through notice-and-comment rulemaking. For example, the Arkansas Insurance Department is authorized to change the technical formatting requirements for data "at any time," without taking public comment. Arkansas Ins. Dep't Rule 100, § 7(B). After the new formatting re-

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[3] A plan fiduciary has a duty to make sure the plan is administered prudently, which includes compliance with applicable laws. See 29 U.S.C. § 1104(a).

quirements are revised, payers can be required to comply with the new requirements in as little as four months. *Ibid.* The potential for rapid change in state data reporting requirements means that self-funded plans and other reporters must *constantly* monitor state regulations and be prepared to revamp their reporting procedures quickly.

In short, the burden of reporting claims data to state APCDs is anything but minor. On the contrary, reporting to APCDs is an onerous obligation that self-funded employer plans must expend considerable financial and human resources in order to meet. And as more and more states create APCDs, that burden is likely to worsen.

3. Congress Enacted ERISA To Prevent Self-Funded Plans From Being Subject To Patchwork State Regulation

The application of so many conflicting and overlapping state regulations to employer benefit plans was precisely what Congress sought to prevent when it enacted ERISA. Congress intended that employer benefit plans would be administered in a single and uniform way across the entire country. Central to that uniform administrative process are the reporting obligations that plans must satisfy. Resp. Br. 17-24. There can be no doubt that state APCD laws—which require that a plan report its participants' medical claims data differently in every state in which the plan operates—"relate to" self-funded employer plans in an impermissible manner and are expressly preempted by ERISA. See 29 U.S.C. § 1144(a).

As *amici* explain *infra* (at pp. 24-29), Congress's primary concern when it enacted ERISA was to en-

sure that plans would be able to meet their obligations to participants and their beneficiaries. One of the most important ways in which ERISA advances this objective is by protecting plans from regulatory requirements that vary from state to state—or even from city to city. Congress believed that complying with many differing state and local regulations would burden plans with high compliance costs. See *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 98-99 (1983) (quoting a sponsor of ERISA who explained on the House floor that the legislation would "'eliminate[e] the threat of conflicting and inconsistent State and local regulation'"). These higher costs, in turn, would eventually fall on beneficiaries in the form of reduced benefits. See, *e.g.*, *Egelhoff* v. *Egelhoff ex rel. Breiner*, 532 U.S. 141, 149 (2001) ("Requiring ERISA administrators to master the relevant laws of 50 States * * * would undermine the congressional goal of 'minimizing the administrative and financial burdens' on plan administrators—burdens ultimately borne by the beneficiaries.") (quoting *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 142 (1990) (brackets omitted)); *FMC Corp.* v. *Holliday*, 498 U.S. 52, 60 (1990) ("To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits."); *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 11 (1987) ("ERISA's pre-emption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those

employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them."). Subjecting employer benefit plans to only a single set of national regulations would reduce plan expenses and hence would foster greater healthcare coverage for beneficiaries.

This Court thus has "not hesitated to apply ERISA's pre-emption clause to state laws that risk subjecting plan administrators to conflicting state regulations." *FMC Corp.*, 498 U.S. at 59. Indeed, this Court has repeatedly struck down state laws that have that undesirable effect. See, *e.g.*, *Egelhoff*, 532 U.S. at 148-49 (holding that a state statute interfered with "nationally uniform plan administration" because it required plan administrators to "familiarize themselves with [different] state statutes" and created the possibility that plan payments would be "subject to conflicting legal obligations"); *FMC Corp.*, 498 U.S. at 60 (holding that a state antisubrogation law was preempted because "[a]pplication of differing state subrogation laws to plans would * * * frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide").

The Court should do the same in this case. The multifarious regulations found in state APCD laws burden self-funded employer plans—particularly national plans—with cumbersome and inefficient reporting requirements, the cost of which ultimately falls on plan beneficiaries. And these reporting requirements relate directly to the core function of self-funded employer plans: their provision of benefits to plan participants. This sort of onerous burden on a core function of self-funded plans was exactly what Congress sought to prevent.

Moreover, if the Court were to hold that APCD laws were not preempted by ERISA, States and municipalities would have no barrier holding back new laws that similarly intrude on plan administration, increasing the regulatory burden on self-funded employer plans even more. Perhaps States would require retirement and pension plans to report data on their investments' performance, for example.

Such a confusing patchwork of state regulations would threaten to "create a system that is so complex that administrative costs * * * unduly discourage employers from offering * * * benefit plans in the first place." *Varity Corp.* v. *Howe*, 516 U.S. 489, 497 (1996). Congress enacted ERISA to prevent that undesirable result. See *Fort Halifax*, 482 U.S. at 11 ("ERISA's pre-emption provision was prompted by recognition that * * * [a] patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them."). This Court should abide by Congress's intent to encourage private welfare plans by holding that Vermont's APCD reporting requirement impermissibly invades the province of ERISA and is expressly preempted.

4. The Decision To Use A Third-Party Administrator Does Not Protect Vermont's APCD Law From Preemption.

In his attempts to argue that state APCD laws like Vermont's do not impose a burden on self-funded employer plans that triggers ERISA preemption, Petitioner relies to a surprising extent on the fact that it is Liberty Mutual's TPA—rather than Liberty Mutual itself—that is subject to reporting requirements

under Vermont's law. See Pet. Br. 1, 23, 31, 38 & n.21, 53-55. Petitioner's position appears to be that because Liberty Mutual's TPA is the party that actually reports data to Vermont's APCD, Liberty Mutual itself cannot possibly be burdened by the reporting requirement.

That position is incorrect, for two reasons. First, as explained *supra*, although Liberty Mutual employs a TPA to operate its self-funded employer plan, some employers do not.[4] And under Vermont's law (and the APCD laws of other states), even companies that do not retain TPAs are responsible for satisfying burdensome reporting requirements. See, *e.g.*, Vt. Regulation H-2008-01, § 3(X); 957 Mass. Code Regs. 2.02. Thus, the burden of state APCD laws—including Vermont's—clearly falls on *some* self-funded employer plans directly, which suffices to make those laws preempted.

Second, from the standpoint of ERISA, there is no legal distinction between legal obligations that fall on a plan sponsor and those that fall on its delegate, such as a TPA. Common sense and basic economics both suggest that the burden of complying with such obligations is ultimately borne by the plan sponsor, irrespective of which party is subject to the obligations in the first instance: if the TPA is responsible for reporting, it will pass on the cost of report-

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[4] *See* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, 78 Fed. Reg. 72,322, 72,340 (Dec. 2, 2013) ("We recognize that some self-insured group health plans self-administer the benefits and services provided under the plan, and do not use the services of a third party administrator.").

ing to its client in the form of a higher price.[5] And even when a plan sponsor delegates a duty (such as data reporting) to a TPA, it retains a fiduciary duty to oversee and monitor the TPA's performance of its tasks. See 29 U.S.C. § 1104(a); see also, *e.g.*, *Jackson* v. *Truck Drivers' Union Local 42 Health & Welfare Fund*, 933 F. Supp. 1124, 1141 (D. Mass. 1996) ("[A] delegating [ERISA] fiduciary retains an obligation to oversee and monitor the activities of his delegate."). This monitoring takes both time and effort on the plan sponsor's part. Either factual scenario, therefore, subjects plan sponsors to the costs of state regulation from which Congress sought to shield them in enacting ERISA.

No principle in ERISA, moreover, suggests that plans can be subjected to inconsistent jurisdiction-by-jurisdiction obligations just because they have sought outside assistance. On the contrary, this Court has held that state laws may not "bind plan administrators to [a] particular choice" about how to structure their plan—such as the choice whether or not to employ a TPA. See *N.Y. State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 659 (1995). Thus, Petitioner's interpretation of ERISA preemption—which would essential-

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[5] The IRS acknowledged this "pass-through" dynamic in its proposals for implementing the Patient Protection and Affordable Care Act's excise tax on high-cost employer health plans. In the notice laying out the proposals, the agency acknowledged that if the excise tax on a self-insured employer plan is paid by its TPA, the TPA is likely to "pass through all or part of the amount of the excise tax to the employer." IRS, Notice 2015-52, *Section 4980I—Excise Tax on High Cost Employer-Sponsored Health Coverage* at 7, https://www.irs.gov/pub/irs-drop/n-15-52.pdf.

ly coerce plans into forgoing TPAs by subjecting them to APCD reporting only when they use TPAs—is surely wrong. ERISA preemption should not and does not depend on whether a plan opts to employ a TPA.

5. APCDs Can Obtain Information From Other Sources—Such As Providers—Without Needing To Burden Self-Funded Plans

Petitioner and his *amici* devote considerable space in their briefs to arguments why APCDs are a useful regulatory tool for states and explanations of the potential benefits they offer to state policymakers. See, *e.g.*, Pet. Br. 12; Am. Hosp. Ass'n & Ass'n of Am. Med. Colls. Br. 16-23. But none of this information is relevant to the issue before this Court—*i.e.*, whether ERISA preempts state APCD laws. If APCD laws impose the sort of burden on self-funded employer plans that Congress sought to avert (and they do), those laws are preempted no matter how high-minded a purpose they serve.

Noticeably missing from Petitioner's brief is any meaningful explanation as to why data from self-insured plans is so critical to Vermont's goals. In fact, Petitioner contradicted that position when he told the district court that self-insured plans account for only a small percentage of the total data collected. Def.'s Opp. to Mot. for Summ. J. 12, *Liberty Mut. Ins. Co.* v. *Kimbell*, No. 2:11-cv-204 (D. Vt. Aug. 17, 2012), ECF No. 48 ("[A]t least two-thirds of Blue Cross' reporting in Vermont pertains to non-ERISA plan members."); see also Pet. App. 69a. It should be noted, however, that if States truly think it important to obtain data on medical care provided to participants in self-funded employer plans, they can

obtain those data from other sources—including, most importantly, the providers who deliver that care.[6] The choice that Petitioner and his *amici* present, between allowing States to maintain comprehensive APCDs on the one hand and respecting ERISA's goal of protecting plans from conflicting state regulations on the other, is therefore a false choice. States can obtain the data they need without imposing regulatory costs on self-funded employer plans—the entities that Congress singled out for special protection in ERISA.

C. THE EXCLUSIVE PURPOSE OF ERISA BENEFIT PLANS IS TO PROVIDE BENEFITS, NOT TO BE LABORATORIES FOR STATE EXPERIMENTATION

State APCD laws not only increase costs for self-funded employer plans; they also conscript plans into the service of the States, turning them into laboratories in which States collect data for their own purposes. This conscription of self-funded plans, whether well-intentioned or not, undermines the goals of ERISA. Congress specified in ERISA that the sole, exclusive purpose of employee benefit plans is to provide benefits to beneficiaries. By forcing plans to divert resources to serve a different and unrelated

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[6] The Centers for Medicare and Medicaid Services (CMS), for example, has made efforts in recent years to collect Medicare claims data from providers and to make those data publicly available for study. See Centers for Medicare and Medicaid Services., *Medicare Provider Utilization and Payment Data: Physician and Other Supplier* (June 1, 2015), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier.html. States could compile similar datasets on non-Medicare claims.

purpose chosen by the state, APCD laws interfere with the legislative scheme that Congress crafted in ERISA.

1. Congress Enacted ERISA In Order to Protect The Interests Of Plan Beneficiaries

In the early 1970s, Congress conducted "a comprehensive and exhaustive study of the private pension plan system in the United States" to investigate concerns about the number of private-sector pension and benefit plans that were becoming insolvent and unable to pay their beneficiaries. This study revealed that many retirement plans did not "meet the obligation[s] promised [to employees] * * * after many years of service." S. Rep. No. 93-127, at 11-12 (1973), reprinted in 1974 U.S.C.C.A.N. 4838, 4847-48. Congress found that "despite the enormous growth in [employee benefit] plans[,] many employees with long years of employment [were] losing anticipated retirement benefits," and that "owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits [was] endangered." 29 U.S.C. § 1001(a). In Congress's view, the precarious financial situation of employee benefit plans was a threat to the "continued well-being and security of millions of employees and their dependents" and, thus, to the "national public interest." *Ibid.*

ERISA was Congress's response to these problems. As its text proclaimed, the statute's animating purpose was "to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries." 29 U.S.C. § 1001 (b); see also, *e.g.*, *Shaw*, 463 U.S. at 90 ("ERISA is a comprehensive statute designed to promote the interests of

employees and their beneficiaries in employee benefit plans."); H.R. Rep. No. 93-533, at 1 (1973), reprinted in 1974 U.S.C.C.A.N. 4639, 4639 ("The primary purpose of the bill is the protection of individual pension rights"). Each of ERISA's safeguards—from requiring plan administrators to disclose more information, to holding fiduciaries to stricter standards of conduct, to requiring plan termination insurance—was designed to further the purpose of protecting plan participants and their beneficiaries. See 29 U.S.C. § 1001(b)-(c). Vermont's plan reporting obligations do not further that purpose.

2. ERISA Mandates That Plans Be Operated For The Exclusive Purpose Of Providing Benefits To Participants

The most important safeguard Congress included in ERISA was the "exclusive purpose" rule of Section 404(a). This rule requires a plan fiduciary to "discharge his duties with respect to a plan *solely* in the interest of the participants and beneficiaries" and "for the *exclusive purpose* * * * of providing benefits to participants and their beneficiaries[,] and defraying reasonable expenses of administering the plan." 29 U.S.C. § 1104(a)(1) (emphases added). Section 403(c) of the statute provides a corollary to the "exclusive purpose" rule, by providing that plan assets are to be used "for the *exclusive purposes* of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan." *Id.* § 1103(c)(1).

The "exclusive purpose" rule is quite stringent: it makes plan participants' interests the *sole* relevant consideration in plan decisionmaking and resource allocation. See, *e.g.*, *Donovan* v. *Bierwirth*, 680 F.2d 263, 271 (2d Cir. 1982) (noting that the exclusive

purpose rule requires that plan trustees' decisions "be made with an eye single to the interests of the participants and beneficiaries."). Indeed, Congress intended that the exclusive-purpose rule would hold plan fiduciaries to an even higher standard than ordinarily applies under state trust law, because Congress "determin[ed] that the common law of trusts did not offer completely satisfactory protection" to beneficiaries. *Varity Corp.*, 516 U.S. at 497. Federal courts have accordingly developed a specialized common law of fiduciary obligations under ERISA "'bearing in mind the special nature and purpose of employee benefit plans.'" *Ibid.* (citing *Firestone Tire Co.* v. *Bruch*, 489 U.S. 101, 110-11 (1989)). In short, the "exclusive purpose" rule is an exceedingly exacting standard—one that reflects Congress's special solicitude for the welfare of participants in employer benefit plans.

3. State APCD Statutes Interfere With Congress's Purpose By Commandeering ERISA Plans For A Different Purpose: Data Collection

State APCD laws like Vermont's are irreconcilable with the "exclusive purpose" rule's clear requirement that plan resources be expended solely for the benefit of participants and beneficiaries, less any incidental expenses of plan administration. APCD laws require plans to expend resources on wholly different priorities that the State has chosen: *i.e.*, collecting, formatting, and reporting data in compliance with the requirements of each State's database. This expenditure of resources does not inure to the sole benefit of plan participants, as ERISA requires; on the contrary, it *harms* beneficiaries, since every dollar spent on data reporting is a dollar that cannot be

spent to meet the plan's obligations to its participants. And it layers on another regulatory scheme requiring distraction from the plan's exclusive purpose of providing benefits.

Petitioner and his *amici* respond to this point by suggesting that the costs imposed on self-funded employer plans by APCD laws are no different from those imposed by any other generally applicable state regulation. See Pet. Br. 27; N.Y. Br. 31, 34. Not so. The expenses of reporting data to APCDs are not akin to taxes or other costs that a plan might ordinarily be expected to incur under state law. On the contrary, APCD reporting is an extraordinary obligation targeted at plans (and a very few other kinds of healthcare enterprises) as a means of conscripting them for the pursuit of specific state policy objectives. See 18 Vt. Stat. Ann. § 9401 (listing policy goals of Vermont's APCD statute). APCD reporting is far from an ordinary cost of doing business in a particular state; it is a deadweight loss that Vermont and other States require plans to absorb for the States' convenience.

This Court should therefore hold that state APCD laws are preempted by ERISA because they "operate[] to frustrate [ERISA's] objects." *Boggs* v. *Boggs*, 520 U.S. 833, 841 (1997). Congress's considered judgment in enacting ERISA was that maintaining a strong and financially sound employee benefit system is crucial to the well-being of millions of American employees and their families and to the strength of the national economy. And Congress concluded that the best way to keep employee benefit plans sound is to ensure that plans are administered for the single and exclusive purpose of providing benefits to participants and their beneficiaries.

When States attempt to use ERISA plans as tools for pursuing their own agendas, ERISA preempts such regulations, irrespective of how high-minded the state's purposes for commandeering the plan's resources or of whether the state's regulatory scheme would be "less useful," Pet. Br. 33, if ERISA plans were excluded from it.

The *only* acceptable use of an ERISA plan is to provide benefits to participants. Vermont's law, which uses ERISA health plans for an entirely different purpose chosen by the State, is therefore preempted.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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IN THE

Supreme Court of the United States

ALFRED GOBEILLE, in his official capacity as chair of the Vermont Green Mountain Care Board,
Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,
Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

BRIEF OF *AMICI CURIAE* AMERICAN HOSPITAL ASSOCIATION AND ASSOCIATION OF AMERICAN MEDICAL COLLEGES IN SUPPORT OF PETITIONER

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INTEREST OF *AMICI CURIAE*[1]

The American Hospital Association (AHA) represents nearly 5,000 hospitals, health systems, and other health care organizations, plus 43,000 individual members. The AHA educates its members on health care issues, and advocates to ensure that their perspectives are considered in formulating health care policy. AHA members are committed to improving the health of their communities, and to ensuring that health care is available and affordable for all Americans.

The Association of American Medical Colleges (AAMC) is a nonprofit educational association, whose members include all 144 accredited U.S. and 17 accredited Canadian medical schools, nearly 400 major teaching hospitals and health systems, and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians. The AAMC's mission is to serve and lead the academic medicine community, to improve the health of all.

Amici have a keen interest in the development and use of all-payer claims databases such as the one at issue in this case. Hospitals and other providers are assessed not only on the quality of the care that they

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[1] Counsel for both the petitioner and respondent have filed, with the Clerk of this Court, blanket consent to the filing of *amicus curiae* briefs. No counsel for any party authored this brief in whole or in part, and no person or entity other than *amici curiae* or their counsel made a monetary contribution to the preparation or submission of this brief.

provide, but on improvements in community health and reductions in the per capita cost of health care. Moreover, both private and public payers are increasingly moving away from volume-based reimbursement to value-based models.

Hospitals and health systems are therefore actively developing, reporting, and making use of data to improve care for patients, improve the health of their communities, and deliver services in the most cost-effective manner possible. The claims databases at the center of this case are essential for achieving those ends, and *amici* strongly support their further use and development. But, as detailed below, to be meaningful, the information in those databases must be *complete*—and that requires including claims data from self-insurers.

INTRODUCTION

The question in this case is whether patients, hospitals, physicians, and policymakers should have access to the kind of data that will enable them to improve the health of their communities while controlling the growth of health care costs. All parties in this case agree that the State of Vermont may lawfully collect health insurance claims data from the State's Medicaid program, and from health insurers operating within Vermont's borders. The only question is whether claims data from self-funding employers—that is, those who pay for their employees' medical expenses themselves, rather than purchasing insurance contracts to do so—should be treated differently.

The court of appeals concluded that employers who self-fund their health insurance plans should enjoy a

special exemption from a generally applicable requirement to report claims data, in a confidential manner, to the State. Pet. App. 3–4. Inclusion of self-insurers' claims data is essential for the proper functioning of the databases at issue in this case, however, and federal law should not be read to preclude it.

Hospitals have been voluntarily leading efforts to gather and report data about cost and quality for more than a decade. That data is necessary to develop evidence-based medicine that can eliminate preventable infections and complications, and better manage chronic illness. Hospitals are using information technology to track the quality of the care they provide, to more deeply involve patients in their care, and to target care to populations in need. Patients and their families, moreover, deserve meaningful information about the price of their care, and America's hospitals are committed to providing it.

But hospitals only have data for the patients they treat. Information from across the spectrum of an individual's health care experience is needed to inform clinical, payment, and public health policy. Only health insurers have this broad range of data. Complete data across all payers (including self-insurers like Respondent) is required so that both health care providers and policymakers can understand the variations in the health care system, and address those that need to change. Access to the fullest possible range of data for the most providers and patients is central to achieving that goal, and will result in higher quality, more efficient care.

SUMMARY OF ARGUMENT

All-payer claims databases are vital and promising public policy tools, the development of which should be actively encouraged, as States are increasingly doing. Analysis of claims data is not new. But a comprehensive, longitudinal, multi-payer dataset—in other words, an all-payer database—can provide unprecedented research and policy opportunities for improving the health care delivery system. Federal law should not be interpreted to preclude the states' use of this tool to best improve the health of their communities.

For example, using the data from all-payer databases, States can develop targeted public health initiatives and interventions—such as evaluating whether patients with particular health conditions are typically receiving nationally recommended screening and procedures. States can evaluate the preventive-care behaviors of their healthy population, to improve care for the rest. They can study the effect of public-education campaigns—and much more. Moreover, all-payer databases can be used to test the effectiveness of pilot programs that offer alternatives to the traditional fee-for-service payment model. An all-payer database can reveal whether such pilots really do reduce costs, and (just as importantly) whether they result in the high quality care.

But for all-payer claims databases to be useful, they must contain *complete* claims data. And given the increasing popularity of self-insured plans, including their claims data is essential. Self-insured plans cover a large majority of the working population: in 2013, nearly 60% of workers with

health insurance were enrolled in such plans, and that figure is growing. See Paul Fronstin, *Self-Insured Health Plans: State Variation and Recent Trends by Firm Size, 1996–2013*, 36 Emp. Benefit Research Inst. at 7 (2015). Some communities have even higher rates: in Illinois, for example, over 92% of employees at large firms are enrolled in self-insured plans. *Id.*, at 9. The self-insured population is also distinctive: excluding it will mean that the population in the database will be, on the whole, older, lower income, and less healthy (because the share of claims information from Medicaid and Medicare will grow). That, in turn, will present a misleading picture that will make it impossible for providers or policymakers to realize the potential benefits of these databases.

Including self-insured claims data, moreover, can be accomplished with little to no direct impact on self-insurers themselves. Most self-insurers, including Respondent, use a third-party insurance company to administer their claims, such as Blue Cross Blue Shield of Massachusetts. See JA 15. For such employers, their administrator maintains all of the information sought by the database. But because the administrators are insurance companies, they will already be in the business of turning over claims data to the state—so the added effort to include self-insurers' data is negligible. Moreover, States can collect claims data (as Vermont does) in nationally standardized formats, which will further reduce any impact on employers and their administrators.

ARGUMENT

I. BASIC FEATURES OF AN ALL-PAYER CLAIMS DATABASE

All-payer claims databases are a fast-growing public policy tool. "As of March 2014, 11 states had an [all-payer database] in place," and "five states were in [the] process of implementation." Paradis & Bartolini, *All Payer Claims Databases: Unlocking the Potential* at 1, Network for Excellence in Health Innovation (Dec. 2014). Many more States have expressed interest in creating such databases, and in total, "more than 30 states have, are implementing, or have strong interest in [all-payer databases.]" Porter, Love, Peters, Sachs & Costello, *The Basics of All-Payer Claims Databases: A Primer for States* 1, APCD Council and Robert Wood Johnson Foundation (Jan. 2014).

State legislation creating all-payer databases directs the periodic collection of claims data from commercial insurance carriers, the State's Medicaid agencies, and (increasingly) Medicare data.[2] The

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[2] See, *e.g.*, Ark. Code Ann. §23-61-901 ("Arkansas Healthcare Transparency Initiative Act of 2015"); Colo. Rev. Stat. §25.5-1-204 (creating advisory committee regarding "creation of all-payer health claims database"); Conn. Gen. Stat. Ann. §38a-1091 ("All-payer claims database program"); 22 Me. Rev. Stat. Ann. §8703 (establishing "Maine Health Data Organization"); Md. Code Health §19-133 ("Maryland medical care data base"); Mass. Gen. Law Ann. ch. 12C, §2 (establishing "center for health information and analysis"); Minn. Stat. Ann. §62U.04 ("Payment reform; health care costs; quality outcomes"); N.H. Rev. Stat. Ann. §420-G:11(II) (requiring insurers to provide "claims data ... to the department of health and human services"); N.Y. Pub. Health Law §2816 ("Statewide planning

resulting database includes medical, pharmacy, and dental claims, combined with eligibility and provider files from private and public payers. Paradis & Bartolini, *supra*, at 1 (all-payer databases "regularly collect medical claims and pharmacy claims data, with some also collecting dental claims and eligibility data, from both private and public payers"). For example, the Vermont statute at issue in this case directs "[h]ealth insurers, health care providers, health care facilities, and governmental agencies" to file "health insurance claims and enrollment information used by health insurers," as well as "any other information relating to health care costs, prices, quality, utilization, or resources" that the responsible state agency directs. Vt. Stat. Ann. tit. 18, §9410(c). Similarly, Arkansas directs insurers to "submit health and dental claims data, unique identifiers, and geographic and demographic information," which shall be "treated as confidential." Ark. Code Ann. §23-61-906(a)–(b). See also R.I. Gen. Laws §23-17.17-10(a)–(b) (directing filing of "health insurance claims and enrollment information used by health insurers," not including "any data that contains direct personal identifiers").

(continued)

and research cooperative system"); Or. Rev. Stat. §442.466 ("Health care data reporting"); R.I. Gen. Laws §23-17.17-9 ("Health care quality and value database"); Tenn. Code Ann. §56-2-125 (establishing "[a]ll payer claims database"); Vt. Stat. Ann. tit. 18, §9410 ("Health care database"); Va. Code Ann. §32-.1-276.7:1 ("All-Payer Claims Database"); Wash. Rev. Code Ann. §43.371.020 ("Statewide all-payer health care claims database"); W. Va. Code §33-4A-1 ("All-payer claims database").

The claims data itself includes, among other things, privacy-protected basic demographic information (such as the patient's sex, age, and zip code); the date and time of the admission and discharge, as well as the status of the patient at discharge; the identity of the service provider; the location where the service was provided; procedures performed; the admitting diagnosis; and the price paid. See Vermont Dep't of Banking, Insurance, Securities, and Health Care Administration, Regulation H-2008-01 (Appendix A).

To safeguard patient privacy, the data is collected, handled, and released in a way that removes individual patient identifiers. Federal laws such as the Health Insurance Portability and Accountability Act (HIPAA) require as much. 42 U.S.C. §1320d-6 (prohibiting "disclos[ure]" of "individually identifiable health information to another person" except as permitted by that Act). See, *e.g.*, 10 Colo. Code Regs. §2505-5:1.200.4 (reports "shall protect patient identity in accordance with HIPAA's standard for the de-identification of protected health information"); R.I. Gen. Laws §23-17.17-10(b) ("All data submitted to the director pursuant to this chapter shall be protected by the removal of all personal identifiers and the assignment by the insurer to each subscriber record of a unique identifier not linked to any personally identifiable information").

States collect this data for several reasons, but the declared purposes are broadly similar. The Vermont database at issue here, for example, exists to help the State in "determining the capacity and distribution of existing resources," "identifying health care needs and informing health care policy," "evaluating the effectiveness of intervention programs on improving

patient outcomes," "comparing costs between various treatment settings and approaches," "providing information to consumers and purchasers of health care," and "improving the quality and affordability of patient health care and health care coverage." Vt. Stat. Ann. tit. 18, §9410.

Other states' statutes express similar goals.[3] Model legislation developed by the APCD Council (an independent group encouraging the adoption and development of these databases) states that such databases should be created to "make available timely and transparent information about health care quality, use, availability, and cost to consumers, researchers, communities, businesses, policy makers, providers, and payers so that they can make sound, economical, and medically appropriate decisions about health care coverage, benefits, and services in order to reduce the overall cost of health care to [the] state." Hodder, Porter, Love & Peters, *Model All-Payer Claims Database (APCD) Legislation* 3, APCD Council and West Health Policy Center (May 2015).

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[3] See, *e.g.*, Ark. Code Ann. §23-61-902(b) (purpose of database is to "[e]mpower Arkansans to drive, deliver, and seek out value in the healthcare system"); Colo. Rev. Stat. §25.5-1-204(a) (establishing a database for the purpose of "facilitating the reporting of health care and health quality data that results in transparent and public reporting of safety, quality, cost, and efficiency information" at all levels of health care); Or. Rev. Stat. §442.466(1) (purpose is "[e]valuating the effectiveness of intervention programs in improving health outcomes" and "[i]mproving the quality and affordability of health care and health care coverage").

II. ALL-PAYER CLAIMS DATABASES ARE AN IMPORTANT PUBLIC POLICY TOOL

Analysis of claims data is not new. But having a comprehensive, longitudinal, multi-payer dataset is now providing unprecedented research and policy opportunities for improving the health care delivery system. Federal law should not be interpreted in a way that would preclude states from using this tool to improve the health of their communities.

A. All-Payer Claims Databases Can Improve Public Health

Claims databases offer the opportunity to improve public health in major ways. First, all-payer claims data can be used to create benchmarks against which "payers and providers can ... conduct performance analyses" and "improve clinical quality." Linda Green, Amy Lischko, and Tanya Bernstein, *Realizing the Potential of All-Payer Claims Databases* at 3, Robert Wood Johnson Foundation (Jan. 2014). This data can be used to improve treatment, strengthen quality measurements, and help develop tools to aid providers in better managing their patients. Claims data can reveal, for example, whether providers "followed nationally recommended medical protocols for treating patients diagnosed with diabetes." Christine Vestal, *Debating the Value of an All-Payer Claims Database*, MedCity News, June 19, 2014. How many diabetic patients in the state, in other words, received quarterly exams? How many received eye exams? How many were admitted to a hospital?

An all-payer database can provide reliable answers to questions like these. An individual provider's data cannot. A hospital cannot reliably document what

happens to their patients once they leave the building. Even an individual insurer can only know how a patient is using care for as long as that patient remains in its network. But a complete set of statewide claims data can be used to analyze patient care and outcomes across *all* service providers and *all* insurers. That creates opportunities for research that simply would not be possible otherwise. In Utah, for example, researchers have used all-payer data about its *healthiest* citizens—such as how they access and use preventive care—in order to study potential improvements to the provision of preventive services to the whole population. See Utah Dep't of Health, *Making Cents of Utah's Healthy Population*, Utah Atlas of Health Care (Oct. 2010).

All-payer databases also can be used to evaluate the impact of public-education campaigns—such as "the impact of tobacco cessation programs" before and after a public-education effort. Green, Lischko, & Bernstein, *supra*, at 2. Because these databases provide a complete picture of a State's health spending, they can answer questions such as how many people are taking advantage of tobacco-cessation programs following a statewide campaign. *Ibid.* The answers, in turn, can be used to design more effective campaigns by better targeting efforts at those populations that are most in need.

Moreover, these databases can be used to support work on patient safety and preventable health care events. See Rexford, Andrews, & Shipley, *The Power of Data: Consumer Involvement and Accountability for Connecticut's All Payer Claim Database (APCD)* (March 2013). States such as "Massachusetts and Colorado are currently working on developing patient

safety and quality reports," using all-payer databases to "identify patient safety problems and patterns to drive improved care." *Id.*, at 14. The Minnesota Department of Health used data from its all-payer database to study the volume and make-up of potentially preventable health care events, by analyzing emergency department visits, hospital admissions, and hospital readmissions. Minn. Dep't Health, *An Introductory Analysis of Potentially Preventable Health Care Events in Minnesota*. And in Colorado, researchers are using all-payer data to study patterns in opioid prescriptions following major surgery, in hopes of increasing "patient safety by finding avenues to optimize non-opioid based [prescription drugs] and to reduce the need for opioid [prescription drugs] for surgical patients following hospital discharge." See Colo. Med. Price Compare Data Showcase, *Identify Opportunities to Reduce Use of Potentially Harmful Medications During and Post Surgery*.

All-payer databases can even measure progress toward reducing "racial and ethnic disparities" in the health care system, by allowing researchers "to stratify analyses across health systems" and "provide evidence for public health and institutional interventions." Rexford, Andrews, & Shipley, *supra*, at 21. Such interventions may include, for example, targeted "outreach communications about preventive services" or comparisons of "the quality of care being provided by various entities serving similar populations." *Ibid.*

Finally, research suggests that patients who take a more active role in their health care decisions have improved health outcomes and experience a higher

quality of care than their less-involved counterparts. See Hibbard, Stockard, Mahoney & Tusler, *Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation in Patients and Consumers*, 39 Health Servs. Research 1005 (2004); Hibbard & Greene, *What the Evidence Shows about Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs*, 52 Health Affairs 207 (2013). As discussed below, all-payer databases make it possible to create (as some states have) consumer-facing websites that report information about price and outcomes at various health care providers. Through these websites, all-payer claims databases enable patients to engage more deeply in their care decisions, and experience improved outcomes.

B. All-Payer Claims Databases Provide Important Information for Individual Patients and Other Stakeholders

The United States is unique among developed nations, in that our health care market is structured by negotiations between employers, insurers, and health care providers, as to both the services that are covered and the prices that will be paid. See Christine Vestal, *Debating the Value of an All-Payer Claims Database*, MedCity News (June 19, 2014). That, in turn, can lead to significant price variations. *Ibid.* All-payer claims databases—because they contain detailed price information about who is paying what for which sorts of treatments, and under what circumstances—can reveal the causes of such price variation, as well as determine where it is reasonable and where it should be reduced.

Patients—especially those who personally bear a significant share of their health care costs—need reliable sources of information for determining how to spend their health care dollars. Some states, such as Colorado, have created websites that make aggregate all-payer data accessible to individual consumers, so that they can evaluate the range of prices for a given procedure. See *Colorado Medical Price Compare*, http://comedprice.org/. On a more systemic level, the aggregate price data benefits employers in designing benefits, understanding utilization patterns, and forecasting likely costs. The California Public Employees' Retirement System (CalPERS), for example, has used data from claims databases for years, describing it as an "invaluable" tool to assist benefit design and rate negotiation. Patrick Miller, *Why State All-Payer Claims Databases Matter to Employers*, Pension and Benefits Daily, at 3 (June 2012).

Indeed, since at least the 1990s, many "larger, self-funded employers" have been requiring their plan administrators and carriers "to deliver reports and data feeds to the employer or their broker for analysis," which those employers could then use to "drive decisionmaking" about benefit design and to better understand utilization. *Id.*, at 2. All-payer databases offer the same potential, but on a systemic level that goes well beyond a single employer or employer coalition. Information is necessary for any market to function well, and these databases are an essential source of information about health care costs.

C. All-Payer Claims Databases Are Essential as Payment for Health Care Moves from Volume to Value

The American health care system is in a transformative period. During the last century, providers were generally paid on the basis of the number of services they performed, under what is known as a fee-for-service model. As costs have increased and resources have decreased, the system has begun to focus on changing payment systems to reward quality (value) rather than amount (volume).

All-payer claims databases offer promising tools to support this effort. For instance, claims databases can be used to track the efficacy of alternatives to traditional fee-for-service models of providing care. Interest in such models is growing, and the Patient Protection and Affordable Care Act repeatedly makes provision for pilot programs designed to experiment with their efficacy. See, *e.g.*, 42 U.S.C. §1395b-1 ("Incentives for economy while maintaining or improving quality in provision of health services") (directing the creation of "experiments and demonstration projects" to "determine whether, and if so which, changes in methods of payment or reimbursement" could "have the effect of increasing the efficiency and economy of health services under such programs through the creation of additional incentives to these ends without adversely affecting the quality of such services").

But such programs must be intelligently evaluated to ensure that they do not compromise the quality of care and that they do, in fact, result in decreased costs over the entire system. All-payer databases can

be an essential tool for doing so. For example, many states "have implemented patient-centered medical home pilots." Porter, Love, Peters, Sachs, & Costello, *supra*, at 2. Those pilots have then been evaluated, in part, using all-payer claims data. See Evaluation Report: NH Multi-Stakeholder Medical Home Pilot (November 2013), at 3 ("The pilot included preliminary analysis of claims data using the ... State's All-Payer Claims Database, to review site performance through claims data").

All-payer databases can be used to answer crucial questions about such pilot programs: Are their patients admitted to hospitals at higher or lower rates? If so, why? Do certain treatments make patients more or less likely to need high-cost interventions later? Is overall patient health maintained? Increased? In the New Hampshire medical home pilot, for example, "sites were able to see blinded comparisons" of cost, utilization, and other data between the pilot and "all other practices in the state." *Id.*, at 7. That sort of information can provide evidence about treatment changes that should be considered, and whether the pilot's model should be expanded to other populations or other disease categories.

III. INCLUDING CLAIMS DATA FROM SELF-INSURED HEALTH PLANS IS ESSENTIAL TO THE EFFECTIVENESS OF ALL-PAYER DATABASES

The public-policy benefits described above are substantial. It is, after all, a rare innovation that presents simultaneous opportunities to improve public health, reduce costs, and increase

transparency. To realize those benefits, however, it is essential that claims from self-insured health plans be included in all-payer claims databases.

As to ordinary commercial insurance providers, there is no dispute that states have the authority to collect claims data as needed to make these databases function. ERISA expressly provides that it does not preempt state laws that "regulate[] insurance." 29 U.S.C. §1144. Therefore, employers who contract with insurers (like Blue Cross Blue Shield or Aetna) to provide traditional, fully-funded health insurance for their employees will automatically have their employees' claims data collected. And as to state-run programs like Medicaid, the State is itself the insurer, and therefore already has the claims data it needs.

Since the enactment of ERISA in 1974, however, it has also been possible for an employer to "self-insure"—that is, to "directly fund[] the health benefits for its covered enrollees." Michael Brien & Constantijn Panis, SELF-INSURED HEALTH BENEFIT PLANS 4 (2011). This option may offer potential advantages to employers, such as control "over the design of the benefits program," or "[i]mproved cash flow generated by keeping funds in-house until needed for payment of claims." *Id.*, at 6. An employer who elects to directly fund its enrolled members' health care expenses, however, will likely still find it convenient to use a third-party insurer to administer claims and payments, as Respondent here did. Liberty Mutual hired "claims administrators" to "process the claims and manage the health care provider networks," which administrators were (depending on the State the employee lived in)

"Aetna or Blue Cross Blue Shield of Massachusetts." JA 113 (excerpt from Summary Plan Description).

State all-payer databases "typically ... collect data on all residents, for both fully insured and self-funded lines of business." Miller, *supra*, at 1. See, *e.g.*, 10 Colo. Code Regs. §2505-5:1.200.1 (including, in the definition of "private health care payer," "a self-insured employer-sponsored health plan"); Vermont Dep't of Banking, Insurance, Securities, and Health Care Administration, Regulation H-2008-01, §3(X) (defining "health insurer" to include "any administrator of an insured, self-insured, or publicly funded health care benefit plan"). That is essential for the long-term success of all-payer databases, for several reasons.

First, self-insured plans cover a large and growing share of the working population. In 1998, 40.9% of workers with health insurance were covered by self-insured plans. See Paul Fronstin, *Self-Insured Health Plans: State Variation and Recent Trends by Firm Size, 1996–2013*, 36 Employee Benefit Research Institute at 7 (2015). By 2002, that number had grown to 50.2%. *Ibid.* By 2006, it had grown to 52.8%. And in 2013, 58.2% of workers with health insurance—nearly six in ten—were covered by self-insured plans. This trend is expected to continue for many reasons, not the least of which is that "that passage of the Patient Protection and Affordable Care Act of 2010" has made "self-insurance ... a more attractive means to mitigate any expected regulatory cost increases." *Id.*, at 2.

Even those rather substantial figures do not tell the whole tale. Large employers are especially likely

to be self-insurers: 83.9% of employers with more than 500 employees self-insure at least one of their health plans, up from 66.2% in 1999. *Id.*, at 4. And in some communities, these numbers are even higher. In Indiana and Nevada, for example, more than 70% of workers with health insurance are covered by self-insured plans. *Id.*, at 9. In Illinois, over 92% of workers at large firms (those with more than 1,000 employees) were enrolled in self-insured plans. *Ibid.* In Vermont, the comparable figure is 90.9%. *Ibid.* An all-payer database that excludes workers in self-insured plans is therefore excluding a majority of the working population, sometimes a supermajority, and is therefore substantially compromised in its capacity to realize the benefits to health, transparency, and cost control described above.

Moreover, different industries self-insure at different rates. Whereas only around 20% of employers in the construction industry and agriculture industry offer a self-insured plan, for example, over 55% of retail employers do. *Id.*, at 4. To the extent that construction workers have different health care needs than retail workers, excluding self-insured claims from these databases will skew the picture painted of the population, by over-counting workers in industries that tend not to self-insure and under-counting those that do. Excluding the self-insured population will also mean that the population in all-payer claims databases will be, on the whole, older, lower income, and less healthy—because it will cause the share of claims information provided from Medicaid and Medicare to grow. That, in turn, will skew the information in ways that will make the databases less useful: it is much harder to

draw conclusions about public health or cost savings without data about the health and costs of most working people.

Including claims data from self-insured plans is not, however, burdensome to the employers. Indeed, it may be completely invisible to them. That is because self-insurers typically "do not manage the claims filed under their self-insured plan themselves; instead they enter into 'administrative services only' contracts with insurers or other claims managers to process claims, resolve disputes, negotiate payment rates, and contract with provider networks." Timothy Jost & Mark Hall, *Self-Insurance for Small Employers Under the Affordable Care Act: Federal and State Regulatory Options*, 68 NYU Annual Survey of American Law 539, 546 (2013). See also Brien & Panis, *supra*, at 4 (duties of a third-party administrator include "resolving disputes, negotiating payment rates, and performing other administrative duties"). That arrangement is common-sense enough: few employers are interested in getting into the business of directly handling their employees' health insurance claims or negotiating rates with providers. Even if the employer is ultimately *paying* the claims by self-insuring, it is often worthwhile to contract for those administrative functions with an outside insurer.

But as a consequence, the distinction "between fully-insured [plans] and self-insured [plans] is not a sharp one." *Ibid.* Indeed, to an employee, "the distinction between an insured plan and a self-insured plan administered by an insurer is invisible." Jost & Hall, *supra*, at 546. They file "their claims with an insurer that pays or denies their claims,

sends them an explanation of benefits, and handles any appeals from claim denials." *Ibid.* Respondent here, for example, designated "Blue Cross Blue Shield of Massachusetts" as the "Plan's third party administrator," in which capacity it "administer[ed] the medical claims and associated confidential medical records of Plan participants and beneficiaries." JA 15.

This arrangement means that it is no burden on self-insurers at all to produce claims data, because their third-party administrator will simply produce it along with all other claims data. The subpoena at issue in this case was not even directed to Liberty Mutual—it was directed to Blue Cross Blue Shield of Massachusetts. JA 21–24. It is not, in other words, that Respondent does not want to assemble and produce the requested data. What it wants is to instruct Blue Cross Blue Shield of Massachusetts, an entity that already produces claims data regularly in its capacity as an ordinary insurance company, *not* to produce information that it already has on file regarding Respondent's employees. See JA 22 ("Liberty Mutual would continue to instruct [Blue Cross Blue Shield of Massachusetts] not to report the claims data").

Even if an employer did not use a third-party administrator for its self-funded plan, the use of nationally standardized codes and formats would make producing the claims data a minimal (or no) burden. Vermont, for example, uses standardized codes from the National Uniform Billing Data Element Specifications, Physicians' Current Procedural Terminology (CPT) Manual, Health Care Common Procedural Coding System, the Centers for

Medicare and Medicaid Services National Provider Identifiers, the National Association of Boards of Pharmacy Database and Listings, and other well-documented, standard data formats, which are in many cases likely to be the format in which claims data is already being generated. See Vermont Dep't of Banking, Insurance, Securities, and Health Care Administration, Regulation H-2008-01, Appendix A. Vermont's regulation also sets out in detail a standardized data format in which claims data is to be produced to the State, using those standardized codes, along with detailed explanations of how Vermont's submission format corresponds to the national standards. *Id.*, at Appendices B1–E2.

In recognizing the value of standardized coding for data submissions, Vermont is not alone. The APCD Council (an all-payer database advocacy group) has issued recommendations regarding standardization of data collection in all-payer claims databases, to encourage "states collecting the same data [to] do so in the same manner." Costello & Taylor, *Standardization of Data Collection in All-Payer Claims Databases*, APCD Council (Jan. 2011). The APCD Council has also promulgated a suggested core set of data elements along with suggested implementation guides. See APCD Medical Data Reporting: Proposed Core Set of Data Elements for Data Submission (Oct. 2011), available at http://www.apcdcouncil.org/sites/apcdcouncil.org/files/media/apcd_council_core_data_elements_5-10-12.pdf. The clear trend, in other words, is toward national standardization, such that the ease of data submission over time is likely to grow.

Self-insured plans cover a large, growing, and distinctive portion of the population. It is essential that they be included in all-payer databases if those databases are to realize their potential, and if America's hospitals are to realize their goal of improving community health and controlling costs while providing the high-quality care for which they are known. This Court should not interpret federal law in a way that would hamper that effort.

CONCLUSION

For the foregoing reasons, the judgment of the Second Circuit should be reversed.

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In the Supreme Court of the United States

ALFRED GOBEILLE, IN HIS OFFICIAL CAPACITY AS CHAIR OF THE VERMONT GREEN MOUNTAIN CARE BOARD,

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

On Writ of Certiorari to the
United States Court of Appeals for the Second Circuit

BRIEF OF *AMICI CURIAE* AMERICAN MEDICAL ASSOCIATION AND VERMONT MEDICAL SOCIETY IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

Whether ERISA's preemption provision, 29 U.S.C. §1144(a), preempts application of a state health-care data collection statute to a self-funded ERISA welfare benefit plan when the law does not regulate the financial disclosures required by ERISA, and, more generally, whether this Court should modify its analysis for determining whether state laws "relate to" employee benefit plans under Section 1144(a).

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INTEREST OF *AMICI CURIAE*

The American Medical Association ("AMA") and the Vermont Medical Society ("VMS") submit this brief as *amici curiae* in support of Petitioner Alfred Gobeille, in his official capacity as Chair of the Vermont Green Mountain Care Board ("Board").[1]

The AMA is the largest professional association of physicians, residents, and medical students in the United States. Through state and specialty medical societies and other physician groups in the AMA's House of Delegates, substantially all United States physicians, residents, and medical students are represented in the AMA's policy-making process. The AMA promotes the science and art of medicine and the betterment of public health. AMA members practice in every medical specialty in all fifty states.

For over a decade, the AMA has litigated to address and correct the flawed databases used by the insurance industry to determine the amounts patients are reimbursed when they obtain medical care from providers outside their health benefit plan's

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[1] Pursuant to Rule 37.6, *amici* state that no counsel for a party authored this brief in whole or in part. *Amicus* AMA joins this brief on its own behalf and as a representative of the Litigation Center of the AMA and the State Medical Societies ("Litigation Center"). No entity or person, other than *amici*, its members, and the Litigation Center made a monetary contribution to the preparation of this brief. Pursuant to Rule 37.3, the parties have consented to the filing of this brief. The parties' letters of consent have been lodged with the Court.

network. These efforts have led to, *inter alia*, investigations by the Attorney General for the State of New York and the United States Senate, substantial reform in insurers' out-of-network reimbursement practices, and hundreds of millions of dollars in settlements from the insurance industry.

More generally, the AMA works for its members to establish equitable procedures and relationships with the nation's health insurers and third-party administrators regarding issues affecting the economic aspects of health care and the practice of medicine.

VMS is a professional association representing over 2,000 physicians, residents, and medical students in Vermont. Founded over 200 years ago, VMS is dedicated to advancing the practice of medicine by advocating for Vermont's doctors and their patients and communities. VMS' mission is to serve the public by facilitating and enhancing physicians' individual and collective commitments, capabilities, and efforts to improve the quality of life for Vermonters by providing accessible, appropriate health care services. VMS physicians represent every medical specialty in every practice setting.

The Litigation Center, which the AMA and VMS represent here, expresses the viewpoint of organized medicine in the courts consistent with the AMA's policies and objectives.

***

Historically, States have regulated both the clinical and economic aspects of the provision of health care, which are often "inextricably mixed." *Pegram v. Herdrich*, 530 U.S. 211, 229 (2000). The Employee Retirement Income Security Act of 1974, 29 U.S.C.

§§1001 *et seq.* ("ERISA"), on the other hand, does not regulate health care, including the practice of medicine. Therefore, insofar as ERISA preempts state regulation in this area, a regulatory void inevitably is created. Where to draw the line between areas of traditional state regulation, like health care, and the exclusive federal regulation of employee benefit plans has bedeviled lower courts and even this Court seemingly since ERISA's enactment.

This case presents another instance of this conundrum. It examines whether Vermont's effort to create an all-payer claims database ("APCD") to compile and analyze medical claims information from all health-care payers and providers within the State "relates to" ERISA-regulated employee benefit plans. *Amici* believe, under this Court's current jurisprudence, Vermont's statute does not "relate to" employee benefit plans. APCDs, like Vermont's, and other independent databases of medical claims information, provide important information to consumers, providers, and policymakers about health care options, outcomes and costs that enable these stakeholders to make more informed decisions about obtaining and paying for medical treatment. *See* Vt. Stat. Ann. tit. 18, §9410(a)(2)(A) (statute provides "transparent health care price information, quality information," and other information to "empower" individuals to "make economically sound and medically appropriate decisions"). As such, statutes creating these databases fall within the ambit of "general health care regulation, which historically has been a matter of local concern." *New York State Conf. Of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995) ("*Travelers*"). Therefore, under this

Court's ERISA preemption analysis, Vermont's statute should not be preempted by ERISA.

This case also highlights the difficulty lower courts, state legislatures, and practitioners have had with ERISA's preemptive scope since its enactment in 1974, even after the Court's effort to re-frame that inquiry twenty years ago in *Travelers*. This case provides the chance to underscore that "[n]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation." *Id.*; *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 (1997) ("historic police powers of the State include the regulation of matters of health and safety").

Cases like this are particularly important to physicians and other medical providers because their profession stands at the intersection of the traditional exercise of a State's police power to regulate medicine and contractual relationships and the increasing dominance of the economics of medicine by health benefit plans which often are regulated by ERISA. The interplay between these regulatory regimes, and particularly ERISA preemption, can have profound economic consequences on the medical profession, particularly as the proportion of workers with health coverage through self-insured (or self-funded) plans increases.[2]

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[2] The percentage of private-sector employees in self-insured plans has increased from 40.9% in 1998 to 58.2% in 2013. Most of that increase has been private sector employees in firms of 1,000 employees or more. In 1998, 57% of those employees had health coverage through self-insured plans. In 2013, that figure

Amici suggest that this case allows the Court to re-examine Section 514(a) and articulate that ERISA §514(a) is really another manifestation of traditional field preemption which simply provides that ERISA supersedes state laws to the extent they "relate to" covered employee benefit plans. Doing so could avoid unnecessary regulatory gaps like the one created by the Second Circuit's decision.

Amici believe ERISA §514 should be reexamined to establish properly the line between regulation of health care (and other traditional state regulatory areas) and the exclusively federal regulation of employee benefit plans. *Amici* propose that the Court refine what it means for a state law to "relate to" an employee benefit plan. 29 U.S.C. §1144(a). *Amici* suggest an analysis that will provide clearer guidance for lower courts faced with ERISA §514(a) preemption issues and will properly restrict field preemption to the area of ERISA's regulatory concerns.

SUMMARY OF ARGUMENT

This case highlights the need to closely examine ERISA's text along with its underlying structure and objectives when deciding whether a state law "relate[s] to" an employee benefit plan. Congress' goal

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rose to 85.6%. *See* Employee Benefit Research Institute, *Self-Insured Health Plans: State Variation and Recent Trends by Firm Size, 1996-2013*, at 7-8. As discussed *infra* at fn.11, while insured plans remain subject to state insurance regulation through ERISA's "insurance savings clause," 29 U.S.C. §1144(b)(2)(A), self-funded plans are not if that regulation "relates to" employee benefit plans because of ERISA's "deemer clause." 29 U.S.C. §1144(b)(2)(B).

in enacting ERISA was to provide: (1) disclosure and other safeguards for establishing, operating, and administering employee benefit plans; and (2) minimum standards to ensure the equitable character of such plans and their financial soundness. 29 U.S.C. §1001(a).

ERISA's preemption provision, ERISA §514(a), states that ERISA "shall supersede any and all State laws insofar as they ... relate to any employee benefit plan." 29 U.S.C. §1144(a). With this provision, Congress intended "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law," "minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government," and prevent "the potential for conflict in substantive law ... requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." *Travelers*, 514 U.S. at 656-57 (citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)).

The Second Circuit held, 2-1, that ERISA preempts application of Vermont's APCD statute to Liberty Mutual's self-funded health benefit plan, as administered by Blue Cross Blue Shield of Massachusetts ("Blue Cross"). *Liberty Mutual Ins. Co. v. Donegan*, 746 F.3d 497, 500 (2d Cir. 2014). It concluded that the statute did not regulate "health care" but instead required reporting by various health care-related entities, including third-party administrators ("TPAs") of self-funded ERISA plans, like Blue Cross, which, according to the court, intruded on "one of ERISA's core functions." *Id.* at 506, n.6, 510. Because of the administrative "burdens" the majority

surmised the statute imposed, which presumably created "financial burdens that will be passed from the TPA to the Plan and from the Plan to the beneficiaries," *id.* at 510, n.10, the majority concluded that the APCD statute was preempted, as applied to ERISA-regulated self-funded plans. *Id.* at 500.

In dissent, Judge Straub concluded that the court should have applied the *Travelers* presumption against preemption. *Donegan*, 746 F.3d at 512-13 (Straub, J., dissenting). He then explained that the majority "misse[d] the nuance of what 'reporting' means in the context of ERISA, and ignore[d] the case law's focus on whether the *administration of benefits to beneficiaries* is impacted," which Liberty Mutual failed to show. *Id.* at 512. The "reporting" Vermont's statute required is "wholly distinct" from ERISA's reporting requirements in 29 U.S.C. §§1020-30, which focus on the financial soundness of ERISA plans. *Id.* at 514.[3] By contrast, Vermont sought "after-the-fact information which plan administrators

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[3] Furthermore, the Secretary of Labor has exempted welfare benefit plans from the reporting requirements at issue if the plan pays benefits from the plan sponsor's general assets (as most do). *See* 29 U.S.C. §1024(a)(3) ("The Secretary may by regulation exempt any welfare benefit plan from all or part of the reporting and disclosure requirements of this subchapter."); 29 C.F.R. §2520.104-44(a)(1), (b)(1) (exemption where plan benefits are paid "solely from the general assets of the employer"); *id.*, §2520.103-1 (annual report requirement exemption); *id.*, §2520.104-20 (same). Liberty Mutual's Plan is self-funded, and its "health care claims are paid from Liberty Mutual's general assets." *Donegan*, 746 F.3d at 501. Therefore, the Plan is generally exempt from the reporting obligations that required preemption.

[like Blue Cross] already have in their possession" and which Blue Cross was not only "happy to provide" but which it did provide for other clients. *Id.* at 515. Any administrative or financial burdens imposed on the Plan's TPA, or derivatively on the Plan (because an ERISA plan and its insurer or TPA are distinct), were simply "indirect economic effects" that do not "preclude uniform administration practice or the provision of a uniform interstate benefit package." *Id.* (quoting *Travelers*, 514 U.S. at 660). Because the APCD statute "regulates health care within that state, while imposing a purely clerical burden on ERISA plans," the dissent concluded that Vermont's statute was not preempted. *Id.* at 518.

The dissent's view follows this Court's jurisprudence, particularly since *Travelers*. The statute is simply a "general health care regulation" that regulates numerous participants in the health care industry, including physicians (and other health care professionals) and "health insurers" as defined by the Vermont legislature. The Vermont statute has, at most, the "indirect" effect on employee benefit plans this Court has held does not require ERISA §514(a) preemption. *Travelers*, 514 U.S. at 659.

For these reasons, *amici* urge this Court to reverse the Second Circuit's judgment. *Amici* also suggest that this Court re-articulate, and perhaps reformulate, its interpretation of ERISA §514(a) preemption to correspond more closely to traditional field preemption. Adopting such a methodology will fulfill ERISA's regulatory concerns while better allowing states to regulate traditional areas of state concern, including health care and avoid creating regulatory gaps where Congress did not intend to create them.

ARGUMENT

I. Independently Created And Maintained Medical Claims Databases Serve Important Health Care Functions.

According to the majority, Vermont's APCD statute "do[es] not regulate the safe and effective provision of health care services, which is among the states' historic police powers." *Donegan*, 746 F.3d at 506, n.8. This conclusion served as a springboard for the majority's conclusion that the statute was preempted. *Id.* That view of the statute, however, glosses over the statutory language, the Vermont legislature's purpose, and the legal environment in which these databases were created. From these perspectives, the APCD statute serves multiple important health care functions and fits squarely within the State's "historic police powers" to regulate "matters of health and safety." *De Buono*, 520 U.S. at 814.

A. The APCD Statute's Text And Purpose Demonstrate It Regulates Health Care.

Title 18 of Vermont's statutes is entitled "Health." Vt. Stat. Ann. tit. 18. According to Vermont's legislature, "[it] is the policy of the state of Vermont that health care is a public good for all Vermonters and to ensure that all residents have access to quality health services at costs that are affordable." *Id.*, §9401(a). The legislature identified numerous overarching principles regarding health care in Vermont, including: (1) "[e]very Vermonter should be able to choose his or her health care providers"; (2) health care costs should be "transparent and easy to understand"; (3) "[t]he financing of health care in Vermont

must be sufficient, fair, predictable, transparent, sustainable, and shared equitably"; and (4) "[t]he system must consider the effects of payment reform on individuals and on health care professionals." *Id.*, §§9371(5), (6), (11), and (12).

Pursuant to these policy goals, the legislature created the Board to improve citizens' health, control health care costs, "enhance[] the patient and health care professional experience of care," retain health care professionals, and simplify health care financing and delivery. *Id.*, §9372. The Board's responsibilities include "establish[ing] and maintain[ing] a unified health care database" to assist the Board and Petitioner in "improving the quality and affordability of patient health care and health care coverage," "improving patient outcomes," and "providing information to consumers and purchasers of health care." *Id.*, §9410(a)(1)(C)-(F). The database is a "resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in Vermont." *Id.*, §9410(h)(3)(B).

The APCD statute requires "[h]ealth insurers, health care providers, health care facilities, and governmental agencies"[4] to electronically submit "health

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[4] "Health insurer" includes "any third party administrator, any pharmacy benefit manager, any entity conducting administrative services for business, and any other similar entity with claims data, eligibility data, provider files, and other information relating to health care provided to Vermont resident[s]." *Id.*, §9410(j)(1)(B). The statute imposes no obligation directly on employee benefit plans. Regulation H-2008-01, §3(X). The Court has distinguished repeatedly between regulating plans

insurance claims and enrollment information used by health insurers" for services provided to Vermont residents; "other information relating to health care costs, prices, quality, utilization or resources"; and "member, subscriber, or policyholder information necessary to determine third party liability for benefits provided." *Id.*, §§9410(c)(1), (3); §9410(h)(1)(C).

It is difficult to square the majority's conclusion that the statute "do[es] not regulate the safe and effective provision of health care services," *Donegan*, 746 F.3d at 506, n.8, with the Vermont legislature's expressed explanation of the APCD statute's purpose within its text, along with the overall statutory framework regulating health care. *Marx v. General Revenue Corp.*, 133 S. Ct. 1166, 1173 (2013) ("As in all statutory construction cases, we assume that the ordinary meaning of the statutory language accurately expresses the legislative purpose.") (internal alterations omitted).

Other States' experiences creating APCDs confirm that they improve health care.[5] They "fill critical information gaps," "support health care and payment reform initiatives," and "address the need for transparency in health care" to help consumers, providers, and policymakers make better decisions. *Id.* APCDs

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and regulating entities, like insurers or service providers, for plans. *See, e.g., Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985); *see also infra*, fn. 11.

[5] Jo Porter, *et al.*, APCD Council, *The Basics of All-Payer Claims Databases: A Primer for States*, at 1 (January 2014). Maine implemented the first APCD in 2003. By 2010, nine more states, including Vermont, did. *Id.*

are a "rapidly emerging ... essential source of information about outpatient services and healthcare payments." National Ass'n of Health Data Organizations, *Key State Health Care Databases for Improving Health Care Delivery*, at 2 (February 2011). They "describe the health care use of the insured population" and "provide information about actual payments – both patient liability and provider payment." *Id.* According to experts, APCDs help "capture" information which States use to "[m]easur[e] and improv[e] health system performance, both clinical and financial, and control[] costs. *Id.* at 4.

The information APCDs compile also provides important data for the evidence-based medicine methodology providers use to help "improve[] patient outcomes." Vt. Stat. Ann. tit. 18, §9401(a)(1)(C); Ariel L. Zimmerman, *Evidence-Based Medicine: A Short History of a Modern Medical Movement*, 15 AMA Journal of Ethics, No. 1: 71-76 (January 2013) (describing importance of quantification and statistics). For example, such evidence helps compare how particular medical procedures are used in different populations or geographic areas, which helps practitioners choose appropriate courses of treatment for their patients. *See* Mark R. Chassin, MD, *et al.*, *How Coronary Angiography Is Used: Clinical Determinants of Appropriateness*, 258 Journal of the American Medical Ass'n No. 18, 2543 (Nov. 13, 1987).

APCDs also help consumers and providers address the opacity surrounding payment for health care. *Amici*, and the federal government, have long asserted that increasing pricing transparency enables more efficient delivery of health care. *See* U.S. Gov't Accountability Office, *Health Care Price Transparency:*

Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care, GAO-11-791, at 28 (September 2011) ("Transparent health care price information – especially estimates of consumers' complete costs – can be difficult for consumers to obtain prior to receiving care.").

B. State Medical Data Collection Efforts Are General Health Care Regulation.

To support its position that ERISA preempted the APCD statute, the majority stated, without citation, that "state health data collection laws do not regulate the safe and effective provision of health care services," and "collecting data can hardly be deemed 'historic'" because APCD laws were only recently adopted. *Donegan*, 746 F.3d at 506, n.8. This focuses the inquiry too narrowly. Even the majority recognized that, when state law "operates in a field that has been traditionally occupied by the States," or when the State employs its "historic police powers" to regulate "matters of health and safety," *id.* (quoting *De Buono*, 520 U.S. at 814), state law presumptively is not preempted. The majority simply believed "state health data collection laws," which require collecting data about medical conditions, practices, and outcomes, did not qualify.

In actuality, health care regulation sweeps more broadly than simply "regulat[ing] the safe and effective provision of health care services." *Donegan*, 746 F.3d at 506, n.8. Title 18, in its entirety, is Vermont's effort to regulate health care within its borders. Its provisions contain everything from public health regulation, to the Board's responsibilities, to health facil-

ity planning, to hospital budget review. *See* Vt. Stat. Ann. tit. 18.

As the dissent explained, the APCD statute "operates in [the] field" of health and safety at least as much as "a revenue raising measure" directed at patient services by certain health care providers. *Donegan*, 746 F.3d at 512-13 (quoting *De Buono*, 520 U.S. at 814). The same logic applies for the unpreempted statute in *Travelers* which made health insurance from Blue Cross entities more cost-effective and the entities more financially viable. *Travelers*, 514 U.S. at 659. Both these statutes are "general health care regulation" Congress did not intend ERISA to displace. *Id.* at 661.

However, even on its own terms, the majority's rationale conflicts with the historical record. States (and colonies) regulated health care and the medical profession according to their police power since before the Revolution. *See* Edward P. Richards, *The Police Power and the Regulation of Medical Practice: A Historical Review and Guide for Medical Licensing Board Regulation of Physicians in ERISA-Qualified Managed Care Organizations*, 8 ANNALS OF HEALTH LAW 201, 202-03 (1999); *Gibbons v. Ogden*, 22 U.S. 1, 205 (1824) ("quarantine and health laws ... are considered as flowing from the acknowledged power of a State, to provide for the health of its citizens."). Even before the Constitution, state and local regulation of health care included gathering information about citizens' medical conditions to protect and improve public health, such as to determine the need for quarantines, and the efficacy of certain medical treatments, like inoculation. *See* Wendy E. Parmet, *Health Care and the Constitution: Public Health and the Role of*

the State in the Framing Era, 20 HASTINGS CONST. L.Q. 267, 287-92 (1993). Historically, then, collecting health care data falls within even a narrow view of "general health care regulation."

C. Independent Medical Claims Databases Are Particularly Important For Health Care Pricing Transparency

Independently created and maintained medical claims databases, like Vermont's APCD, also increase transparency for health care costs which benefits both health care consumers and providers. *Amici*'s litigation experience demonstrates the need for such independently maintained databases. Indeed, *amici*'s experience, along with the 2008 New York Attorney General's Office's "industry-wide investigation" into health insurance industry practices concluding that the health insurance industry systematically underpaid benefits to "over 100 million Americans" who received out-of-network medical care, potentially spurred the subsequent proliferation of APCD statutes like Vermont's. *Deceptive Health Insurance Industry Practices: Are Consumers Getting What They Paid For? – Part I Before the S. Comm. on Commerce, Science, and Transportation*, 111th Cong. 4-5 (March 26, 2009) ("*Deceptive Practices, Pt. I*") (statement of Linda A. Lacewell, Counsel, Office of the New York Attorney General).

In 2000, *amicus* AMA and others filed a class-action against United HealthCare ("UHC"), the nation's second largest health insurer, and its wholly-owned subsidiary, Ingenix, asserting that insurers systematically relied on skewed data, created and maintained in an Ingenix database, to determine out-

of-network payment rates to patients or their providers.[6] *See Deceptive Practices, Pt. I, supra*, at 6, 13 (statement of Dr. Nancy H. Nielsen, President, AMA); *American Med. Ass'n v. United HealthCare*, 588 F.Supp.2d 432 (S.D.N.Y. 2008). When consumers are reimbursed, or providers are paid, for out-of-network services, insurers (or plans) pay them a percentage of the usual, customary, and reasonable ("UCR") rate providers charge when they have not negotiated a lower in-network rate. *Deceptive Practices, Pt. I, supra*, at 5, 7. The consumer then typically remains responsible for the balance of the bill. *Id.* at 7.

At the time, this database was essentially the *only* national database of information about medical claims and charges. Insurers provided data for the database which was then used by the insurance industry to determine the UCR rates on which insurers would base their provider payments. Plaintiffs alleged that this data was inaccurate and manipulated to artificially reduce rates insurers paid by deleting high charges, using outdated data, and co-mingling retail charges with lower, negotiated rates. *Id.* at 13.

The AMA's litigation prompted investigations by the New York Attorney General's office in 2008 and a United States Senate subcommittee in 2009. Each reached scathing conclusions about the health insurance industry's use of the flawed database. *See* Office of the Attorney General, State of New York, *Health*

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[6] In 2009, 70% of insured Americans had a health benefit plan that allowed them to choose an out-of-network doctor, paid for with higher premiums and usually higher co-pays or co-insurance. *Id.* at 5.

Care Report – The Consumer Reimbursement System is Code Blue (January 13, 2009);[7] Staff Report for Chairman Rockefeller, *Underpayments to Consumers By The Health Insurance Industry*, S. Comm. on Commerce, Science, and Transportation, Office of Oversight and Investigations (June 24, 2009) ("*Senate Report*").

The New York Attorney General found that the health insurance "industry use[d] a conflict-laden database riddled with errors at the expense of the consumer." *AG Report*, *supra*, at 6. The database created an "industry-wide problem" and a "rigged system" that was "fraudulent" and "critically ill." *Id.* at 6, 22. In essence, insurers' use of the database to determine UCR amounts was "unreliable, inadequate, and wrong – often forcing consumers to bear an even greater burden of the cost of care." *Deceptive Practices, Pt. I*, *supra*, at 8.

The Attorney General's report concluded that insurers' use of the data the industry compiled and maintained to calculate UCR rates created "conflicts of interest from top to bottom" because every insurer "had a financial incentive to manipulate the data they provided" "so that the pooled data would skew reimbursement rates downward." *Id.* at 8. The report ultimately found that this system resulted in, "insurers systematically under-reimburs[ing] New Yorkers" up to 20%. *Id.*

The Senate Report reached similar conclusions, finding that the industry's database was used "to un-

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[7] http://www.ag.ny.gov/health-care/report ("*AG Report*").

der-pay millions of valid insurance claims" "without providing even the most basic information about [it] to consumers or health care providers." *Senate Report*, *supra*, at i. Because of the data inaccuracies, the database "consistently skewed reimbursement rates downwards – in a direction that allowed insurers to reduce their claims payments" by "as much as 30% lower" than market rates. *Id.* at ii.

Ultimately, insurers settled with the Attorney General and *amicus* AMA for over $450 million collectively. *Deceptive Practices, Pt. I*, *supra*, at 9, 13, 25. The Attorney General also required two structural reforms. "First, the [UCR] rates for health care charges should be determined by an independent third party free of conflicts of interest, using a fair, objective, and reliable database. ... Second, before consumers choose an out-of-network doctor, they should have a range or estimate of what it will cost them. ... A website tool available to the public, showing at least common health care services and the market rates in relevant geographic areas, would help transparency in health care." *AG Report*, *supra*, at 3.

The Attorney General therefore required the database to be transferred to an independent non-profit, FAIR Health, Inc., which would develop a "conflict-free, robust, trusted and transparent source of data to support the adjudication of healthcare claims and to promote sound decision-making by all participants in the healthcare industry."[8] FAIR Health has now cre-

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[8] http://www.fairhealthus.org/About-FH.

ated the National Private Insurance Claims Database, the nation's largest independent private claims collection. *See* Sean Nicholson, *Research Opportunities of a New Private Health Insurance Claims Data Set.* But even that only includes approximately 23.4% of national payments for privately insured patients by their insurers, to say nothing of patients insured by non-private insurance or government programs, like Medicare or Medicaid. *Id.* Because this new database collects only some of the existing medical claims data nationwide, state-wide efforts, like Vermont's, are more important than ever.

II. ERISA Does Not Preempt The Vermont Statute Because It Does Not "Relate To" Employee Benefit Plans Under ERISA §514(a).

This Court established twenty years ago that the "starting presumption" for ERISA §514(a)'s preemption analysis is that "Congress does not intend to supplant state law," especially when the "state action [occurs] in fields of traditional state regulation," like health care. *Travelers*, 514 U.S. at 654-55. Section 514 did not "alter [the] ordinary assumption that the historic police powers of the States were not to be superseded by [ERISA]," *California Div. of Labor Stds. Enforcement v. Dillingham Constr*, 519 U.S. 316, 331 (1997), absent the "clear and manifest purpose of Congress." *Travelers*, 514 U.S. at 655. Therefore, "relates to" does not "extend to the furthest stretch of indeterminacy." *Id.*

With this starting point, the Vermont statute does not "relate to" employee benefit plans so it is not preempted. 29 U.S.C. §1144(a). Instead, the state statute regulates health care – a traditional area of

state concern. The Vermont statute lies far afield from ERISA's regulatory scope and concerns.

A. The Vermont Statute Regulates Health Care, A Traditional State Concern.

Vermont's APCD statute requires numerous participants that provide and pay for medical care, including "health insurers," to submit electronically "health insurance claims and enrollment information used by health insurers," information about "health care costs, prices, quality, utilization or resources," and information needed to "determine third party liability for benefits provided." Vt. Stat. Ann. tit. 18, §§9410(c)(1), (3); §9410(h)(1)(C).

As enacted, Vermont's APCD statute falls squarely within the realm of "general health care regulation" that remains viable despite ERISA §514(a). This Court has explained repeatedly that "[n]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. at 661; *Pegram*, 530 U.S. at 237 ("in the field of health care, ... there is no ERISA preemption without [a] clear manifestation of congressional purpose."); *Hillsborough Cty. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 719 (1985) (regulating health and safety "is primarily, and historically, a matter of local concern."); *De Buono*, 520 U.S. at 808 ("hospitals operated by ERISA plans are subject to the same laws as other hospitals.").

This Court also has held that the economic regulation of health care does not "relate to" employee benefit plans pursuant to ERISA § 514(a), although such

regulation may have an indirect, or even direct, economic effect on ERISA plans. *Travelers*, 514 U.S. at 659 ("indirect economic effect" of hospital bill surcharges does not "relate to" ERISA plan); *De Buono*, 520 U.S. at 815-16 (tax on hospital run by ERISA plan does not "relate to" plan despite direct impact on plan). "[C]ost uniformity was almost certainly not an object of pre-emption." *Travelers*, 514 U.S. at 662.

Like the state laws in *Travelers* and *De Buono*, the Vermont statute is another health care regulation that at most (and only hypothetically) "increase[s] the cost of providing benefits to covered employees [and so] will have some effect on the administration of ERISA plans." *De Buono*, 520 U.S. at 816. However, that effect alone "simply cannot mean" that the statute "relate[s] to" ERISA plans and is preempted by ERISA §514(a). *Id.* Even if "added compliance cost ... may ultimately be passed on to the ERISA plan, ... such 'indirect economic effects,' are not enough to preempt state regulation even outside of the insurance context." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 399, n.11 (2002) (quoting *Travelers*, 514 U.S. at 659).

B. The Vermont Statute Does Not "Relate To" ERISA Plans.

"A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Travelers*, 514 U.S. at 656 (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983)). "[R]eference to" only applies if a statute "acts immediately and exclusively upon ERISA plans" or "the existence of ERISA plans is essential to the law's operation." *Dillingham*, 519 U.S.

at 325. Vermont's statute applies to health care providers, government agencies, and other entities other than health insurers (including, but not limited to TPAs for self-funded plans like Liberty Mutual's). Vt. Stat. Ann. tit. 18, §§9410(c), (j)(1).[9] Therefore, the statute has no impermissible "reference to" employee benefit plans.

The question, therefore, is whether the statute has an impermissible "connection with" such plans. The majority concluded that the APCD statute does, as applied to Blue Cross' administration of Liberty Mutual's self-funded ERISA plan, because the statute intruded on a "core ERISA function," *i.e.*, "reporting," which is "shielded from potentially inconsistent and burdensome state regulation." *Donegan*, 746 F.3d at 508.

The majority, however, misperceived the appropriate ERISA §514(a) inquiry. This Court examines both "'the objectives of the ERISA statute as a guide to the scope of the state law that Congress under-

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[9] Since Blue Cross provides administrative services to plans exempt from ERISA (like government or church plans), those plans are still subject to the statute. *See* 29 U.S.C. §§1003(b)(1), (2). For Blue Cross' insured plans, the APCD statute presumably is saved from preemption by the insurance savings clause. 29 U.S.C. §1144(b)(2)(A). So, multiple categories of employee benefit plans remain subject to the APCD statute. As the record reflects, other self-insured ERISA plans Blue Cross administers abide by the statute voluntarily. *Donegan*, 746 F.3d at 515. This further suggests that any "burden" on Blue Cross, or the plan derivatively, is largely theoretical. It also highlights the difference between the employee benefit plan and the TPA or insurer that provides services or insurance to the plan.

stood would survive,'" and "the nature of the effect of the state law on ERISA plans," to "determine whether [the] state law has the forbidden connection" with ERISA plans. *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (quoting *Dillingham*, 519 U.S. at 325). Examining ERISA's objectives and the "effect of the state law on ERISA plans," *id.*, demonstrates that §514 does not preempt the APCD statute's application to self-insured plans.

"[I]n enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employee benefits from accumulated funds." *Dillingham*, 519 U.S. at 326-27 (quoting *Massachusetts v. Morash*, 490 U.S. 107, 115 (1989)). Therefore, Congress "established extensive reporting, disclosure, and fiduciary duty requirements to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator." *Id.* (quotation omitted).

ERISA's preemption provision addresses this primary concern by preempting several types of state regulation, particularly state laws that "mandate[] employee benefit structures or their administration," *Travelers*, 514 U.S. at 658, "provid[e] alternative enforcement mechanisms" for procuring plan benefits, *id.*, or "require[] employers to provide certain benefits" or govern the calculation of benefits. *De Buono*, 520 U.S. at 815. The APCD statute mandates nothing like these prohibited activities.

Focusing on ERISA's reporting requirement leads to the same conclusion. As the dissent explained, "under ERISA, plans must report information that goes to the financial integrity of the plan." *Donegan*,

746 F.3d at 514. Even this requirement is typically "limited to the furnishing of a summary plan description to plan participants and an annual report to the Secretary." *Id.* (citing 29 U.S.C. §§1021-30).

The APCD statute neither addresses nor impinges on these obligations, particularly for self-funded plans. As an initial matter, the Secretary of Labor has exempted Liberty Mutual's Plan (and other welfare benefit plans that pay benefits from the plan sponsor's general assets) from these reporting requirements. *See* 29 U.S.C. §1024(a)(3); *see also supra* at fn.3. But assuming *arguendo* that these reporting requirements governed the Liberty Mutual Plan, they are far afield from the statute's requirement that health insurers, including TPAs, provide "after-the-fact information" which they "already have in their possession." *Donegan*, 746 F.3d at 515. Vermont's APCD statute does not ask for information about the plan's "financial integrity," *id.* at 514, and ERISA's reporting requirements do not address anything like the topics sought pursuant to the APCD statute. *See Self-Insurance Institute of America, Inc. v. Snyder*, 761 F.3d 631, 638 (6th Cir. 2014) (ERISA only preempts "state laws requiring ERISA entities to file reports related to the plans' financial stability"). Therefore, there should be no preemption where there simply is no overlap, let alone conflict,[10] be-

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[10] The lack of conflict between the APCD statute and ERISA demonstrates that traditional conflict preemption does not apply, and the majority's reliance on *Boggs v. Boggs*, 520 U.S. 833, 840 (1997), is misplaced. *Donegan*, 746 F.3d at 506, n.8 (citing *Boggs*). This Court decided *Boggs* using conflict preemption principles and did not "inquire whether the statutory phrase

tween the state and federal requirements which do not even address the same types of information. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 16 (1987) ("It would make no sense for pre-emption to clear the way for exclusive federal regulation, for there would be nothing to regulate.").

Examining the "effect of the state law on ERISA plans," *Egelhoff*, 532 U.S. at 147, compels the same conclusion. The "basic thrust of the preemption clause ... was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Travelers*, 514 U.S. at 657 The APCD statute does not impair the nationally uniform administration of employee benefit plans. As the dissent noted, "[t]he distinction between general administration and administration of plans, claims, and benefits is important." *Donegan*, 746 F.3d 516. "Many state laws may have an impact on the administration of an ERISA plan – for example, a work-place safety law, a prevailing wage law, or a law that requires companies to report employment data." *Id.* Even though "[s]uch laws may impose additional costs, or require additional administrative resources," "none of these laws impact *how benefits are administered to beneficiaries* and, therefore, they are not preempted by ERISA." *Id.* (citing *Dillingham*, 519 U.S. at 319).

Having "some effect on the administration of ERISA plans" does not require preemption, *De Buo-*

'relate to' provides further and additional support for the pre-emption claim." *Boggs*, 520 U.S. at 841.

no, 520 U.S. at 816, particularly when the law simply "alters the incentives, but does not dictate the choices, facing ERISA plans." *Dillingham*, 519 U.S. at 334. This is particularly so for economic "burdens." As discussed in *Travelers*, imposing indirect economic costs on ERISA plans does not merit preemption. Only if the "state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers," would the state law be pre-empted. *Travelers*, 514 U.S. at 668.

Here, there is no evidence, except rhetorical, of burden, let alone evidence that the APCD statute "force[s] an ERISA plan to adopt a certain scheme or substantive coverage," *id.*, or "dictate[s] the choices" of ERISA plans. *Dillingham*, 519 U.S. at 334.

To the contrary, the evidence showed that Blue Cross (and other similarly-situated TPAs) "already have in their possession" the required information. *Donegan*, 746 F.3d at 515 (Straub, J., dissenting). Indeed, Blue Cross is "happy to provide the data Vermont has asked for, and it does so for other clients." *Id.* Blue Cross also presumably provides the same type of information for its insured plans (because of ERISA's insurance savings clause, 29 U.S.C. §1144(b)(2)(A)), or for plans exempt from ERISA, like church plans or governmental plans. 29 U.S.C. §§1003(b)(1), (2). Thus, it would plausibly create more "burden" on a TPA/insurer like Blue Cross to exempt the self-insured plans it administers from the statute's requirements while requiring those same obligations for its insured and ERISA-exempt plans.

It is also important to understand modern-day commercial realities. The unsubstantiated "burden" about which Liberty Mutual complains (since Blue Cross does not complain about it) does not involve collecting new information, creating new records, or amassing, compiling, and retaining piles of paper documents that would not otherwise be generated. Rather, it involves simply uploading digital documents that health care providers and insurers (or plan TPAs) already have to the Vermont database's website. *Donegan*, 746 F.3d at 515. Health providers and insurers perform virtually the same tasks, with these same records, countless times daily as providers submit claims for payment electronically to health insurer/TPAs and insurer/TPAs communicate with providers regarding these claims and/or electronically remit payment for them.

Because Vermont's statute does not "relate to" employee benefit plans under this Court's jurisprudence, particularly post-*Travelers*, the Second Circuit's analysis should be reversed.[11]

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[11] Though appropriately interpreting "relates to" makes a savings clause analysis unnecessary, another basis for reversing the majority's decision is that it is saved from preemption by the insurance savings clause. 29 U.S.C. §1144(b)(2)(A). The APCD statute does not attempt to regulate self-funded ERISA plans; instead, it regulates, *inter alia*, insurers and TPAs, like Blue Shield, who process claims for self-funded ERISA plans. This Court has distinguished between permissible regulation of service providers to self-funded plans and impermissible direct regulation of ERISA plans themselves. *See FMC Corp. v. Holliday*, 498 U.S. 52, 65 (1990) (discussing "Congress' clear intent to exempt from direct state insurance regulation ERISA *em-*

III. ERISA §514(a) Preemption Should Be Clarified.

Despite this Court's statements since *Travelers*, the Second Circuit held that the Vermont statute "relate[s] to" employee benefit plans. This and similar holdings in the lower courts highlight the persistent lack of clarity concerning the scope of "relate to" preemption under ERISA §514(a). Preemption under §514(a) operates as field preemption, with the States ousted of all regulatory authority over matters that "relate to" ERISA plans. Section 514(a) preemption therefore potentially creates regulatory voids. This is not a problem where Congress intended to create a regulatory gap, such as leaving unregulated employer decisions whether to offer benefit plans. However, it is a problem when there is no indication that Congress intended to preclude States from regulating areas like health care and the practice of medicine. There is a strong need, therefore, to better define the scope of "relate to" preemption and thereby specify the boundary of the preempted field.

This Court has expressed concern that the boundaries of ERISA §514(a) "relate to" preemption are difficult to discern. *Travelers*, 514 U.S. at 655 ("we have to recognize that our prior attempt to construe the

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ployee benefit plans."). Insured plans, and TPAs for self-insured plans, remain "open to indirect regulation" by insurance regulations, because of the interplay between the savings clause and the deemer clause. *Metropolitan Life*, 471 U.S. at 747; *Rush Prudential*, 536 U.S. at 371 (nothing "stand[s] in the way of applying the savings clause ... [to] a contractor that provides only administrative services for a self-funded plan.").

phrase 'relate to' does not give us much help drawing the line here.") (internal citation omitted); *De Buono*, 520 U.S. at 813. It has also grappled repeatedly with how to derive substance from the limiting phrase "relate to" and thereby set meaningful boundaries to the scope of §514(a). *Travelers*, 514 U.S. at 655 ("[if] 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course, for 'really, universally, relations stop nowhere.'") (internal citation omitted); *Dillingham*, 519 U.S. at 329 ("if ERISA were concerned with any state action – such as medical-care quality standards or hospital workplace regulations – that increased costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we could scarcely see the end of ERISA's pre-emptive reach, and the words 'relate to' would limit nothing.").

Amici therefore propose refining ERISA §514(a)'s preemption analysis to more clearly separate the areas occupied by ERISA's exclusive federal regulation from other areas of state regulation, like health care and the practice of medicine. The basics of this approach are straightforward. First, the scope of ERISA's regulatory domain should be identified based upon the structure and content of ERISA as a whole. Second, the scope of field preemption under ERISA §514(a) should be congruent with ERISA's regulatory domain. This approach gives meaningful content to §514(a)'s language. It preempts state laws where it makes substantive sense to do so. It also maintains the Court's traditional "starting presumption" that "Congress does not intend to supplant state law," particularly in areas of "traditional state regulation." *Travelers*, 514 U.S. at 654-55. Therefore, it

respects "the separate spheres of governmental authority preserved in our federalist system," *Fort Halifax*, 482 U.S. at 19, and avoids the "unsettling" possibility that ERISA §514(a) "results in the pre-emption of traditionally state-regulated substantive law in those areas where ERISA has nothing to say." *Dillingham*, 519 U.S. at 330.

A. ERISA Regulates Employee Benefit Plans And Relationships Between Plans And Other ERISA-Regulated Entities.

ERISA's core focus is upon the establishment, content and operation of the "employee benefit plan." An employee benefit plan is the formal mechanism through which a plan sponsor (usually the employer) provides benefits to employees and related plan beneficiaries. 29 U.S.C. §§1002(1)(A), 1002(3).

An ERISA plan is "established and maintained pursuant to a written instrument." *Id.*, §1102(a)(1). That instrument must identify at least one named fiduciary with authority to control and manage the plan's operation and administration, including the responsibility to deny benefit claims. *Id.*, §1102(a)(1), §1133(2). Every employee benefit plan must also establish procedures for funding and amending the plan, allocating responsibility for operating the plan, and specifying how payments are made to and from the plan. *Id.*, §1102(b).

A plan must provide a summary plan description ("SPD") to plan participants and beneficiaries, written in plain English, which summarizes the plan. *Id.*, §1122; 29 C.F.R. §2520.102-3 (SPD contents). An employee benefit plan must afford plan beneficiaries a process for reviewing benefit denials. 29 U.S.C.

§1133(2). It is also a distinct legal entity that "may sue or be sued" for plan benefits and other purposes. *Id.*, §1132(d)(1).

ERISA regulates the administration of employee benefit plans by imposing reporting and disclosure requirements regarding the plan's financial integrity, *id.*, §§1021-31 (except for exempted welfare benefit plans), participation and vesting requirements (except for welfare benefit plans), *id.*, §§1051-61, funding obligations (except for welfare benefit plans), *id.*, §§1081-86, and administrative provisions and civil and criminal enforcement provisions. *Id.*, §§1131-45.

ERISA regulates more than the plan itself. It also regulates the relationships between plans and other specified entities and individuals. Principally, these other entities and individuals are the "employer" or "plan sponsor," *id.*, §1002(5), §1002(16)(B), the plan "participant" or "beneficiary," *id.*, §1002(7) and (8), the plan "administrator," *id.*, §1002(16)(A), and plan "fiduciar[ies]." *Id.*, §1002(21)(A).

Some courts have called these entities the "traditional ERISA entities," *Bullock v. Equitable Life Assur. Soc. of U.S.*, 259 F.3d. 395, 399 (5th Cir. 2001), and limited ERISA preemption to addressing "the relationships among the core ERISA entities." *Donegan*, 746 F.3d at 507 (quoting *Stevenson v. Bank of N.Y. Co.*, 609 F.3d 56, 61 (2d Cir. 2010)); *Hattem v. Schwarzenegger*, 449 F.3d 423, 429-32 (2d Cir. 2006);

Gerosa v. Savasta & Co., 329 F.3d 317, 324 (2d Cir. 2003).[12]

ERISA imposes comprehensive decision-making duties on plan fiduciaries, 29 U.S.C. §1104, imposes liability to the plan for breaching those duties, *id.*, §§1105, 1109, and prohibits certain transactions between a plan and a plan fiduciary. *Id.*, §1106(b). ERISA imposes obligations on the employer or sponsor to fund the plan and maintain records, *id.*, §§1059, 1082, 1083, prohibits the employer from using plan assets for its own benefit, *id.*, §1103(c), and restricts the plan's ability to purchase the employer's securities. *Id.*, §1107. The plan administrator, who may be the plan sponsor, has various disclosure obligations, including the duty to file annual and other reports for the plan, *id.*, §§1021, 1023-24, along with notices of significant reductions in benefit accruals. *Id.*, §1054(h). Regarding plan participants and beneficiaries, ERISA prescribes the plan's obligations to participants for the accrual and payment of plan benefits, *id.*, §§1054, 1056, creates a private right of ac-

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[12] *See also Access Mediquip L.L.C. v. UnitedHealthcare Ins. Co.*, 662 F.3d 376 (5th Cir. 2011), *reinstated en banc*, 698 F.3d 229 (5th Cir. 2012) ("whether the claims affect an aspect of a *relationship* that is comprehensively regulated by ERISA" determines preemption); *Penny/Ohlmann/Nieman, Inc. v. Miami Valley Pension Corp.*, 399 F.3d 692, 698 (6th Cir. 2005) (same); *Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Group, Inc.*, 187 F.3d 1045, 1053 (9th Cir. 1999) (same); *Morstein v. National Insurance Services, Inc.*, 93 F.3d 715, 722 (11th Cir. 1996) ("when a state law claim brought against a non-ERISA entity does not affect relations among principal ERISA entities as such," no preemption); *Lordmann Enterp., Inc. v. Equicor, Inc.*, 32 F.3d 1529, 1533 (11th Cir. 1994) (same).

tion against the plan, *id.*, §1132(a), and provides a participant with a right to a notice of denial benefits claimed under the plan. *Id.*, §1133.

To a much lesser extent, ERISA addresses the relationship between plans and insurance companies. (Though insurer/TPAs often muddy this distinction to benefit from preemption, it should go without saying that the plan and the insurer or TPA are separate entities). ERISA acknowledges that plans may provide welfare benefits to plan participants "through the purchase of insurance or otherwise." *Id.*, §1002(1). ERISA obligates an insurer that provides plan benefits or holds plan assets to provide information to the plan administrator for the plan's annual report. *Id.*, §1023(a)(2)(A). It establishes requirements for ensuring the adequacy of an insurer's assets when an insurance policy has been purchased for the benefit of participants in an employee pension benefit plan. *Id.*, §1101(b), (c). However, ERISA does not presume that a relationship between an employee benefit plan and an insurer necessarily exists. Moreover, if that relationship exists, ERISA does not comprehensively regulate it. Rather, ERISA cedes to the states almost all the regulation of the insurer-plan relationship via the insurance savings provision. 29 U.S.C. §1144(b)(2)(A). Finally, ERISA does not directly regulate medical providers, or other third-party service providers (like TPAs), at all.

B. The Scope Of ERISA §514(a) "Relate To" Field Preemption Should Coincide With ERISA's Domain.

ERISA §514(a)'s "relate to" provision should preempt a field co-extensive with ERISA's regulatory

domain – that is, ERISA §514(a) should only preempt state laws that primarily regulate employee benefit plans (including their establishment, content, or administration) or the relationships between plans and other entities and individuals that ERISA regulates. This construction gives meaning to the statutory term "relate to," because the preempted field should encompass more than state laws regulating the plan itself. It also gives meaning to ERISA §514(a)'s preemption provision as a whole, because the result is field preemption (rather than merely conflict preemption based upon specific statutory provisions). *Cf. Dillingham*, 519 U.S. at 335-36 (Scalia, J., concurring) ("it accurately describes our current ERISA jurisprudence to say that we apply ordinary field preemption, and, of course, ordinary conflict preemption"); *Egelhoff*, 532 U.S. at 152-53 (Scalia, J., concurring); *id.* at 153-54 (Breyer, J., dissenting).

For example, ERISA does not require employers to have employee benefit plans or "mandate what kinds of benefits employers must provide if they choose to have [an employee benefit] plan." *Pegram*, 530 U.S. at 226-27. Nevertheless, because ERISA §514(a) preempts the field encompassed by ERISA's regulatory domain (which begins with the employee benefit plan itself), States may not mandate the benefits such plans must provide. *Dillingham*, 519 U.S. at 328. Similarly, because ERISA's domain encompasses the relationship between the plan and plan administrator, a state law that dictates aspects of that relationship "relate[s] to" the plan – regardless of whether ERISA addresses that aspect of the relationship. *See UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 378-79 (1999) (state law making the "policyholder-employer the agent of the insurer.").

This reading of "relates to" reinforces ERISA's overarching statutory objectives. It preserves for exclusive federal regulation those areas that ERISA regulates but does not potentially create regulatory voids beyond ERISA's regulatory scope. This analysis also helps clarify the scope of ERISA §514(a)'s field preemption. The boundaries of the preempted field are delimited by ERISA's regulatory scope.

At the same time, statutes that regulate relationships between ERISA plans and parties not regulated by ERISA fall outside the scope of ERISA field preemption under *amici*'s proposed construction of §514(a). *See Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 833 (1988) ("lawsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan" are not preempted). Likewise, laws of general application that do not regulate employee benefit plans but may have some economic or other "effect" on them are not within the field preempted by §514(a). *See Travelers*, 514 U.S. at 659; *Dillingham*, 519 U.S. at 334; *De Buono*, 520 U.S. at 815-16. Areas that States historically regulate, like medicine, are even further afield from ERISA's regulatory domain and are not preempted, consistent with the Court's traditional presumption against preemption. *Pegram*, 530 U.S. at 236-37 (mixed eligibility and medical treatment decisions are outside ERISA's domain); *Travelers*, 514 U.S. at 654-55.

Focusing the ERISA §514(a) analysis, therefore, on whether the state law primarily regulates the establishment, content or administration of an employee benefit plan or its relationships with other ERISA-

regulated entities gives meaningful content to §514(a). It also defines the scope of ERISA field preemption in ways that coincide with the statute as a whole, while leaving States able to regulate within their traditional "separate sphere[] of governmental authority." *Fort Halifax*, 482 U.S. at 19. By more clearly defining the field preempted by §514(a)'s "relate to" provision, the areas of state law that lie outside the preempted field, including health care and the practice of medicine, are more easily identifiable.

C. State Laws Regulating Health Care Are Outside ERISA's Domain And So Outside The Field ERISA §514(a) Preempts.

Vermont's APCD statute is not preempted by ERISA §514(a) under the construction *amici* advocate. First, the APCD statute does not regulate employee benefit plans. As discussed in Part IA, *supra*, it regulates various actors that provide and pay for health care, including health care providers and insurers (including TPAs for self-insured plans). Second, it does not regulate the relationship between ERISA's "core," "principal," or "traditional" entities. Rather, it operates independently of any connection to an ERISA plan, is directed at entities ERISA does not directly regulate, and does not regulate ERISA relationships in any meaningful way.

For these reasons, the Vermont statute does not "relate to" employee benefit plans under ERISA §514(a). It directly and primarily regulates a sphere not governed by ERISA and entities not regulated by ERISA. The statute therefore does not relate to em-

ployee benefit plans and is not within the field preempted by ERISA §514(a).

CONCLUSION

Applying the Court's *Traveler's* analysis, Vermont's APCD statute does not "relate to" employee benefit plans. It is simply "general health care regulation" reserved to the States and undisturbed by ERISA. This case also suggests that refocusing the ERISA §514(a) preemption analysis on the "employee benefit plan" and the plan's relationships with other ERISA-regulated entities will provide the Court with a more useful way to analyze "relate to" preemption. *Amici's* proposed analysis adheres to the statutory text and the objectives of both ERISA's substantive provisions and preemption provision. Under this analysis, Vermont's APCD statute clearly is outside the field preempted by ERISA §514(a).

The judgment below should be reversed.

Respectfully submitted,

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No. 14-181

IN THE

Supreme Court of the United States

ALFRED GOBEILLE, IN HIS OFFICIAL CAPACITY AS CHAIR OF THE VERMONT GREEN MOUNTAIN CARE BOARD,

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF OF *AMICI CURIAE* ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC., AND THE VERMONTERS FOR HEALTH CARE FREEDOM, IN SUPPORT OF NEITHER PARTY

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QUESTION PRESENTED

Vermont requires health care providers and health care payers to produce claims data and related information to the State's health care database. The law applies to all public and private entities that pay for health care services, including insurers, government programs, and third-party administrators. The State purportedly uses the database to inform health care policy.

Amici curiae will address the following question:

Did the Second Circuit err in holding in favor of patient medical record privacy, by deciding that ERISA preempts Vermont's health care database law as applied to the third-party administrator for a self-funded ERISA plan?

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Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

INTERESTS OF *AMICI CURIAE*[1]

Since 1943, *Amicus* Association of American Physicians and Surgeons, Inc. ("AAPS") has been a membership organization dedicated to preserving the ethical standards of the Oath of Hippocrates and the sanctity of the patient-physician relationship. AAPS has filed numerous *amicus curiae* briefs in noteworthy cases like this one. *See, e.g., Stenberg v.*

[1] No counsel for a party authored this brief in whole or in part. No person or entity other than *Amici*, its members, or its counsel made a monetary contribution to the preparation or submission of this brief. *Amici* file this brief with the blanket written consent by all parties, which they have filed with the Court.

Carhart, 530 U.S. 914, 933 (2000) (citing an AAPS *amicus* brief).

Amicus Vermonters for Health Care Freedom ("VHCF") is a non-profit organization founded in 2011 in order to educate the public and legislators on issues relating to health care policy in Vermont. Specifically, VHCF opposes a government monopoly over health care and the adverse impact it will have in Vermont on patients and the economy. VHCF sponsors forums, makes presentations to community and professional groups, appears on public policy television and radio programs, and serves as an expert resource.

Amici have a direct and vital interest in this case by virtue of their goals to protect medical record privacy for patients.

SUMMARY OF ARGUMENT

The appellate decision below protects medical record privacy against intrusion by a Vermont regulatory scheme that requires production to the State of massive amounts of data related to individual care of patients. The Second Circuit properly found that there was a "significant" risk to the privacy of patients associated with the demand by Vermont for the wholesale transfer of medical records about unsuspecting patients. *Petition for a Writ of Certiorari Appendix* ("Pet. App.") 29 n.13. By construing the Employee Retirement Income Security Act of 1974 ("ERISA") in a manner consistent with patient privacy, the ruling below comports with teachings of this Court in favor of a full privilege of confidentiality in some medical records and a right of

privacy in others. ERISA should be interpreted in a manner that safeguards patient privacy, and the decision below was correct in doing that.

Short of affirming the decision below, the optimal result would be for this Court to dismiss the writ of *certiorari* as having been improvidently granted. This would leave intact the analysis below that protects privacy, while epitomizing judicial restraint on an issue that has not yet been fully vetted by the various Circuits. Indeed, there is no Circuit split, and no disagreement with a ruling by this Court arising from the Second Circuit decision, and it should remain in effect based on a dismissal of the writ.

ARGUMENT

Under threat of a $10,000 fine per violation, Vermont broadly requires "that any entity ... possessing ... [any] information relating to health care provided to Vermont residents or by Vermont health care providers and facilities" comply with the following:

> regularly submit medical claims data, pharmacy claims data, member eligibility data, provider data, and other information relating to health care provided to Vermont residents and health care provided by Vermont health care providers and facilities to both Vermont residents and non-residents in specified electronic format to the Department for each health line of business ....

Pet. App. 5-6 (citing Vt. Stat. Ann. tit. 18, § 9410(g) for the fine; quoting Vt. State Regulation H-2008-01, §§ 3(X), 4(D), for the reporting requirement).

The decision below was right in holding, after considering the privacy issue, that the Vermont regulatory scheme is preempted by ERISA, and this Court should dismiss the writ of *certiorari* as having been improvidently granted.

I. THE DECISION BELOW WAS CORRECT BASED ON MEDICAL RECORD PRIVACY GROUNDS.

The court below made a factual finding that the Vermont statute creates a significant risk to the privacy of patients' medical records. The Second Circuit expressly held:

> The overview of requirements (set out above) makes clear that Vermont requires ERISA plans to record, in specified format, massive amounts of claims information and to report that information to third parties, ***creating significant (and obvious) privacy risks*** and financial burdens that will be passed from the TPA to the Plan and from the Plan to the beneficiaries. That is not a proper allocation of plan assets.

Pet. App. 29 n. 13 (emphasis added).

This Court should reject the proposition, urged upon it by Petitioner in its brief, that "[t]he statute and rule protect personal privacy." Pet. Br. at 11. Breaches of the privacy of databases are so widespread and commonplace now that it can hardly be doubted that when medical record data is assembled and transferred in such large quantities, as the Vermont statute requires, then it is foreseeable that a privacy breach will inevitably occur. *See, e.g.*, "When identity theft isn't news,"

Deseret Morning News (Salt Lake City) (August 26, 2015) ("Thieves took the personal information of at least 22 million federal employees from the Office of Personnel Management.").

Yet Petitioner insists that patient privacy will be protected because "[t]he statute ... mandates that confidential information be 'filed in a manner that does not disclose the identity of the protected person,'" Pet. Br. 11, quoting Vt. Stat. Ann. tit.18 § 9410(e), by "prohibit[ing] submission of 'direct personal identifiers,' ... including names, addresses, and Social Security numbers." Pet. Br. 11, quoting Vt. State Regulation H-2008-01 § 7(A)(5) and Vt. Stat. Ann. tit.18 § 9410(h)(3)(D). But scholars have disproven the myth that privacy in medical records is attained by removing "direct personal identifiers" as Petitioner pretends. A team at Harvard was able to identify 84-97% of the individuals in a DNA database despite its lack of several personal identifiers. The researchers cross-referenced public voter registrations lists and used dates of birth. *See* Latanya Sweeney, Akua Abu, Julia Winn, "Identifying Participants in the Personal Genome Project by Name," supported by a National Institutes of Health Grant.[2] Professor Sweeney even showed how private medical information about then-Governor William Weld of Massachusetts could be publicly disclosed through the process of "re-identification". *See id.* at 2; *see also* Latanya Sweeney, "k-anonymity: a model for protecting privacy," *International Journal on Uncertainty,*

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[2] http://dataprivacylab.org/projects/pgp/1021-1.pdf (viewed Aug. 28, 2015).

Fuzziness and Knowledge-based Systems 557-70 (2002).[3]

Petitioner repeatedly quotes the dissent below for its statement that there was "no evidence" of a risk to privacy under the Vermont statute. Pet. Br. 22, 52. But in fact the dissent did not specifically and adequately address the privacy issue, and instead merely asserted that it is speculation to recognize the Vermont regulatory scheme as being "time-consuming and risky." Pet. App. 46 (Straub, J., dissenting, quoting panel decision at Pet. App. 25). Yet the risk is real, and the privacy rights of patients are plainly implicated by Vermont's demand for massive amounts of medical record data so broad in scope that this could easily harm individual patients in a relatively small State such as Vermont. A hacker, an intentional leak of this information, or perhaps simply a freedom of information-type request could yield private medical information that might ruin the career of a political candidate or employee.

In *Whalen v. Roe*, this Court recognized that medical record privacy interests are substantial, and that state laws implicating them are to be analyzed with something more than a mere rational-basis standard of review. "The right to collect and use such [medical] data for public purposes is typically accompanied by a concomitant statutory or regulatory duty to avoid unwarranted disclosures" and "in some circumstances that duty arguably has its roots in the Constitution ...." *Whalen v. Roe*, 429 U.S. 589, 605 (1977). "Unquestionably, some

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[3] https://epic.org/privacy/reidentification/Sweeney_Article.pdf (viewed Aug. 28, 2015).

individuals' concern for their own privacy may lead them to avoid or to postpone needed medical attention," the Court observed. *Id.* at 602.

While this Court ultimately upheld the reporting requirement imposed by the State of New York in *Whalen*, the Court did so before the pervasive hacking and leaking of personal information that exists today. The *Whalen* Court cautioned that the outcome could be different in "a system that did not contain comparable security provisions." *Id.* at 606. *See also* Roger S. Magnusson, "Symposium Article: Part 4: Privacy: The Changing Legal and Conceptual Shape of Health Care Privacy," 32 J.L. Med. & Ethics 680, 681 (Winter, 2004) (explaining that in *Whalen* this Court "appeared to recognize an intermediate level of protection for information privacy claims falling somewhere between the compelling state interest approach (that applies where state legislation would interfere with fundamental liberty interests), and the more easily-satisfied rational relation test, where it would not") (inner quotations omitted).

In *Jaffee v. Redmond*, the Court went further and held that "confidential communications between a licensed psychotherapist and her patients in the course of diagnosis or treatment are protected from compelled disclosure under Rule 501 of the Federal Rules of Evidence." 518 U.S. 1, 15 (1996). The Court added that this:

> psychotherapist privilege covers confidential communications made to licensed psychiatrists and psychologists. We have no hesitation in concluding in this case that the federal privilege should also extend to confidential communications

> made to licensed social workers in the course of psychotherapy.

Id. at 15.

As with other privileges, the purpose of the psychotherapist-patient is to protect the relationship and avoid the chilling effect that disclosure would have on that relationship. The Vermont statute, while pretending to protect privacy, breaks down the "trust" in confidentiality that the Court has determined to be of paramount concern. "Like the spousal and attorney-client privileges, the psychotherapist-patient privilege is 'rooted in the imperative need for confidence and trust.'" *Id.* at 10 (quoting *Trammel v. United States*, 445 U.S. 40, 51 (1980)). It matters not whether a government thinks its safeguards against hacking and data breaches are adequate, but whether patients lose their "confidence and trust" by virtue of the mandated disclosures.

In another context, the Court has cited favorably the Oath of Hippocrates, which contains a strong protection of privacy dating back nearly 2500 years:

> All that may come to my knowledge in the exercise of my profession [as a physician] ... which ought not to be spread abroad, ***I will keep secret and never reveal***.

Oath of Hippocrates of Kos, 5th century B.C. (emphasis added).[4] This Court has described the Oath of Hippocrates as "a long-accepted and revered statement of medical ethics." *Roe v. Wade*, 410 U.S. 113, 132 (1973) (embracing the Oath of Hippocrates despite disagreeing with its provision relating to

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[4] http://www.aapsonline.org/ethics/oaths.htm (viewed August 25, 2015).

abortion).

Dissenting from the Court decision that approved warrantless wiretaps in *Olmstead v. United States*, Justice Brandeis characterized patient-physician communications as being privileged on the same level as the attorney-client relationship:

> communications that are private and privileged – those between physician and patient, lawyer and client ....

Olmstead v. United States, 277 U.S. 438, 487 (1928) (Brandeis, J., dissenting), *overruled by Katz v. United States*, 389 U.S. 347, 353 (1967). Justice Brandeis's view, of course, eventually commanded a majority with respect to protection by the Fourth Amendment of telephone conversations against government wiretaps.

It is a factual issue whether the Vermont statute comports with basic privacy for patients in their medical records, and this factual question was essentially resolved against the Vermont statute by the Second Circuit. This Court should not grapple anew with this same factual question. *See, e.g.*, *Thompson v. Louisiana*, 469 U.S. 17, 23 (1984) ("a factual issue" is "unsuitable for our consideration in the first instance," this Court observed). Whatever security protections that Vermont insists are in place to safeguard the privacy of the data were obviously not persuasive to the Second Circuit. This Court should not make a different factual finding based on such a meager record here on the privacy issue.

In addition to *Whalen*, other decisions by this Court have recognized that there are "constitutionally protected privacy rights in matters of personal life." *Nixon v. Adm'r of General Servs.*,

433 U.S. 425, 457 (1977). *See also McVane v. FDIC (In re McVane)*, 44 F.3d 1127, 1138 (2d Cir. 1995) (holding that there is an "'intermediate' level of scrutiny to laws requiring individuals to disclose personal financial information"). ERISA preemption should be construed as consistent with these privacy concerns, as the Second Circuit correctly held below.

II. THE WRIT OF *CERTIORARI* SHOULD BE DISMISSED AS HAVING BEEN IMPROVIDENTLY GRANTED.

The privacy of medical records is central to this case but it has not been fully litigated and is not even addressed by the Question Presented as formulated by Petitioner. Yet a decision by this Court would have a significant impact on the fundamental issue of medical record privacy with respect to governmental databases. Rather than decide this matter without adequate vetting by the lower courts first, the appropriate resolution is to dismiss the writ of *certiorari* as having been improvidently granted.

There was no substantive dissent below from the finding by the panel majority that the Vermont regulatory scheme posed "significant" and "obvious" risks to privacy. The current posture of this case does not permit the Court to fully address and resolve the underlying privacy issue. A decision upholding the enforceability of the Vermont regulatory scheme against ERISA plans would have the effect of eroding, *sub silentio*, patient medical record privacy and the teaching of *Whalen v. Roe*.

The dilemma here falls within the rich history of this Court in dismissing a case, without resolving the

Question Presented, in order to preserve the issue for another day. As this Court explained *per curiam* more than 50 years ago:

> While this Court decides questions of public importance, it decides them in the context of meaningful litigation. Its function in resolving conflicts among the Courts of Appeals is judicial, not simply administrative or managerial. Resolution here of the extent to which [this issue] may be given effect by our courts can await a day when the issue is posed less abstractly.

The Monrosa v. Carbon Black Export, 359 U.S. 180, 184 (1959).

Supreme Court procedure facilitates this result by allowing a writ of *certiorari* to be granted based on merely four votes, such that upon further consideration five votes may later dismiss the same writ:

> The vote of four Justices is sufficient to grant a petition for certiorari, but that action does not preclude a majority of the Court from dismissing the writ as improvidently granted after the case has been argued. *See, e. g., NAACP v. Overstreet*, 384 U.S. 118, 16 L. Ed. 2d 409, 86 S. Ct. 1306 (1966) (dismissing, after oral argument, writ as improvidently granted over the dissent of four Justices). We have frequently dismissed the writ as improvidently granted after the case has been briefed and argued; in fact, we have already done so twice this Term. *See Gibson v. Florida Bar*, 502 U.S. 104, 116 L. Ed. 2d 432, 112 S. Ct. 633 (1991); *PFZ Properties, Inc. v. Rodriguez*, 503 U.S. 257, 117 L. Ed. 2d 400, 112 S. Ct. 1151 (1992).

United States v. Williams, 504 U.S. 36, 60 n.7 (1992) (Stevens, J., dissenting). Such dismissal is appropriate here to avoid premature resolution of a thorny constitutional issue of medical record privacy. In words apt here, Justice Stevens explained in his concurrence with a high-profile dismissal of a writ as improvidently granted:

> this Court has appropriately decided to dismiss the writ as improvidently granted centers around the importance of the difficult First Amendment questions raised in this case. As Justice Brandeis famously observed, the Court has developed, "for its own governance in the cases confessedly within its jurisdiction, a series of rules under which it has avoided passing upon a large part of all the constitutional questions pressed upon it for decision." *Ashwander v. TVA*, 297 U.S. 288, 346, 80 L. Ed. 688, 56 S. Ct. 466 (1936) (concurring opinion). The second of those rules is that the Court will not anticipate a question of constitutional law in advance of the necessity of deciding it. *Id.*, at 346-347, 80 L Ed 688, 56 S Ct 466. The novelty and importance of the constitutional questions presented in this case provide good reason for adhering to that rule.

Nike, Inc. v. Kasky, 539 U.S. 654, 663 (2003) (Stevens, J., concurring, joined by Ginsburg and Souter). Likewise, the "novelty and importance" of the constitutional issue of privacy here weigh against ruling on the issue before there is a Circuit split below.

The writ for *certiorari* was granted here after six States submitted an amicus brief insisting that review by this Court was necessary, but upon closer

look their arguments do not withstand scrutiny. *See Brief for the States of New York, Maryland, Massachusetts, New Hampshire, Oregon, and Utah as Amici Curiae in Support of Petitioner*. Their brief argues that at least sixteen States have a data collection program "of this type" (*id.* at 1), yet barely a third of those States joined their amicus brief and its lead State, New York, estimates that it is still a year away from its program becoming operational. (*Id.* at 2-3) The States' amicus brief then asserts that a prominent achievement of this data collection was to discover in 2011 that one in six hysterectomies may be unnecessary (*id.* at 6), but the same point about unnecessary hysterectomies was fully reported by CNN as having "long been a concern" years earlier, in 2007. Curt Pesmen, "5 operations you don't want to get – and what to do instead," *CNN* (July 27, 2007) ("There's long been a concern, at least among many women, about the high rates of hysterectomy ... in the United States. American women undergo twice as many hysterectomies per capita as British women and four times as many as Swedish women.").[5]

The medical profession can do a far better job of reducing health care costs, without invading patient privacy, than States can do in violation of it. ERISA does not exist to permit some States to run roughshod over patient privacy. A more complete record on the privacy issue is warranted before the floodgates are opened for a third of the States to become Big Brother.

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[5] http://www.cnn.com/2007/HEALTH/07/27/healthmag.surgery/index.html?iref=newssearch (viewed Aug. 26, 2015).

The Department of Justice urged this Court not to grant *certiorari* in this case, and pointed out that there is neither a Circuit split nor any disagreement by the decision below with a ruling by this Court. *See Brief for the United States as Amicus Curiae* (On Petition), dated May 2015, at 21 ("no square conflict exists over the question presented at this time"); *id.* at 18 (explaining that there is no conflict with any decisions by this Court, which "in fact, has not considered a state law similar to the Vermont scheme"). Lacking a proper basis for a writ of *certiorari*, and in light of how the arguments by Petitioner in seeking a writ of *certiorari* were disproven by the United States, the writ should be dismissed.

CONCLUSION

For the foregoing reasons, the writ of *certiorari* should be dismissed as improvidently granted.

Respectfully submitted,

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No. 14-181

IN THE

Supreme Court of the United States

ALFRED GOBEILLE, IN HIS OFFICIAL CAPACITY AS CHAIR OF THE VERMONT GREEN MOUNTAIN CARE BOARD,

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF OF *AMICUS CURIAE* BLUE CROSS AND BLUE SHIELD ASSOCIATION IN SUPPORT OF RESPONDENT

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INTEREST OF *AMICUS CURIAE*[1]

The Blue Cross and Blue Shield Association ("BCBSA") is the trade association that coordinates the national interests of the independent, locally operated Blue Cross and Blue Shield companies ("BCBSA Member Companies"). Together, the 36 independent, community-based and locally operated BCBSA Member Companies administer health benefit plans or provide health insurance to more than 100 million people – almost one-third of all Americans – in all 50 states, the District of Columbia, and Puerto Rico. The BCBSA Member Companies offer a variety of products supplying administrative services or insurance to all segments of the population, including private and public employer groups, small businesses, and individuals.

The BCBSA Member Companies are subject to regulations under a variety of federal and state statutes, including the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001 *et seq.* This case concerns whether ERISA preempts a Vermont law – Vt. Stat. Ann., tit. 18, § 9410, known as an all-payer claims database ("APCD") statute – requiring, among others, third-party administrators of self-funded ERISA plans and insurers of insured ERISA plans to report data about claims to a Vermont state agency. In their role as third-party administrator to or insurer of ERISA plans, BCBSA's Member Com-

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[1] Petitioner and Respondent have each filed letters granting blanket consent to the filing of *amicus curiae* briefs in support of either or neither party. Pursuant to Rule 37.6, the *amicus* states that no counsel for a party authored this brief in whole or in part, and no person or entity, other than the *amicus*, its members, or its counsel, made a monetary contribution to the preparation or submission of the brief.

panies are subject to Vermont's law or other states' APCD laws, insofar as such laws apply to them. They, therefore, have a substantial interest in the question whether ERISA preempts the Vermont statute and similar APCD laws existing in other states.

SUMMARY OF ARGUMENT

I. This case offers the opportunity for a necessary update of some of the governing ERISA express preemption principles emanating from *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995). The use of a presumption against ERISA express preemption, as *Travelers* invokes, is inharmonious with the Court's developing jurisprudence on express preemption provisions generally and with other ERISA precedents that have warned against the use of presumptions when construing ERISA statutory terms. Additionally, the *Travelers* preemption regime devolves, in practice, to a standard close to ordinary conflict preemption, which unduly restricts a preemption clause that Congress anticipated, at the time of enactment, would be expansive. And *Travelers* and its progeny have not brought greater predictability to the ERISA preemption area, with lower courts (as the majority and dissent did here) continuing to diverge on whether similar state laws are preempted under ERISA's preemption clause, 29 U.S.C. § 1144(a).

In order to bring better order to the area, the Court should discard a presumption against ERISA preemption, leaving § 1144(a) to be applied without artificially tipping the balance in favor of the states and against federal interests. Another important improvement the Court can make is to reinvigorate

the "reference to" component of ERISA express preemption, whereby state laws that refer to ERISA plans are found to "relate to any employee benefit plan" (29 U.S.C. § 1144(a)) and thus be preempted. The Court has taken much power from the "reference to" benchmark by indicating it applies where a state law applies exclusively to ERISA plans. The Court should return to the rubric adopted in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), by finding ERISA to preempt a state law that facially includes ERISA plans or their essential actors among its regulatory objects. The test is easily applied and truer to ERISA's text. Vermont's APCD law would succumb under that "reference to" test.

II. Even without any adjustment to the current ERISA express preemption framework, the Vermont law is preempted. Under *Travelers* and its progeny, a state law "relates to" (in the sense it has a "connection with") ERISA plans and is therefore preempted when it interferes with ERISA's objectives. Because one of ERISA's main goals is to ensure uniform, exclusively federal reporting by ERISA plans, and because Vermont's law upsets that goal, the Vermont statute is preempted under § 1144(a). In further support of Respondent, the *amicus* emphasizes two points key to the preemption analysis. First, ERISA's reporting obligations – and thus a subject on which Congress sought uniform standards – include reporting on *medical claims data*. The Affordable Care Act expressly incorporated into ERISA transparency requirements contained in the Public Health Service Act, and those requirements are intricate and cover the same ground as Vermont's APCD law. Second, the compliance burdens created by Vermont's law and other states' similar laws are immense, especially for multi-state ERISA plans.

ARGUMENT

I. THE COURT SHOULD REVISE ITS ERISA EXPRESS PREEMPTION JURISPRUDENCE

A. *The Preemption Standards Articulated in Travelers and Its Progeny Are in Need of Updating*

Twenty years have passed since *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) ["*Travelers*"], a decision that "marked something of a pivot in ERISA preemption." Pet. App. 18. While intended to adjust an existing body of decisions that the Court believed did "not give us much help drawing the line" for ERISA preemption (*Travelers*, 514 U.S. at 655), *Travelers* itself is now in need of repair. One threshold rule it set forth for preemption – namely, a presumption against express preemption – is now in tension with the Court's since-developed case law in other preemption contexts and even in other ERISA settings. Moreover, the post-*Travelers* regime aligns too closely to ordinary "conflict" preemption. And *Travelers* and its progeny have not lessened unpredictability in this area of the law.

1. ERISA's preemption section states that "the provisions of [ERISA] . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b)." 29 U.S.C. § 1144(a). ERISA §§ 4(a) and 4(b), in turn, extend ERISA's coverage to any employee benefit plan established or maintained by a private employer or employee organization (such as a union) and exempt plans operated by government employers and churches (along with a few others). *See id.* § 1003(a)-(b). Of course, the key words of the preemption sec-

tion, and the ones that have spawned so much discussion in the case law, are those bringing within the section's compass state laws that "relate to any employee benefit plan."

Faced once again, after many prior attempts, with the challenge of interpreting those words, the Court in *Travelers* announced – for the first time – that there would be a presumption against preemption when applying ERISA's express preemption section. "[T]he starting presumption [is] that Congress does not intend to supplant state law." *Travelers*, 514 U.S. at 654. Thus, in ERISA cases, including in *Travelers* itself, "where federal law is said to bar state action in fields of traditional state regulation," the courts must "work[] on the 'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.'" *Id.* at 655 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

Next, the Court registered "frustrat[ion]" with its earlier attempts to construe § 1144(a). *Travelers*, 514 U.S. at 656. "Relate to" is a phrase that, on its face, does not "do much limiting." *Id.* at 655. From early on, attempting to give content to the text, the Court had explained that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw v. Delta Air Lines*, 463 U.S. 85, 96-97 (1983). But the "connection with" language, proved to be scarcely "more help than . . . 'relate to.'" *Travelers*, 514 U.S. at 656. "For the same reasons that infinite relations cannot be the measure of preemption, neither can infinite connections." *Id.* And the "reference to" prong of the standard often did not

aid matters because the Court, in *Travelers* and then subsequent cases, said it applies to the narrow and infrequent situation "[w]here a State's law acts immediately and exclusively upon ERISA plans, . . . or where the existence of ERISA plans is essential to the law's operation." *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 325 (1997) ["*Dillingham*"]; *accord Travelers*, 514 U.S. at 656.

Accordingly, to go "beyond the unhelpful text," at least on the "connection with" side of things, the Court emphasized that ERISA preemption decisions should be tied to the statute's underlying purposes. The courts must "look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Travelers*, 514 U.S. at 656. In *Travelers*, the Court also identified the underlying purpose most relevant to preemption inquiries: with the preemption section, "Congress intended 'to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.'" *Id.* at 656-57 (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)) (alterations in original).

The Court in *Travelers* also surveyed its past decisions and noted the types of state laws that would fail under the revamped preemption regime. In so doing, the Court provided the lower courts with a sort of shorthand checklist of the types of state laws

that would conflict with ERISA's goal of uniform national regulation and not survive merely on the presumption against preemption. Referring to its prior precedents, the Court said: "In each of these cases, ERISA pre-empted state laws that mandated employee benefit structures or their administration. Elsewhere, we have held that state laws providing alternative enforcement mechanisms also relate to ERISA plans, triggering pre-emption." *Id.* at 658 (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *FMC Corp. v. Holliday*, 498 U.S. 52 (1990); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990)).

2. *Travelers* – especially its presumption against preemption – has become out of step with the Court's more general preemption jurisprudence. In recent cases, several Justices have criticized the use of a presumption against preemption in express preemption contexts. As Justice Scalia has stated, joined by three other Justices:

> I remain convinced that "[t]he proper rule of construction for express pre-emption provisions is . . the one that is customary for statutory provisions in general: Their language should be given its ordinary meaning." *Cipollone v. Liggett Group, Inc.*, 505 U. S. 504, 548, 112 S. Ct. 2608, 120 L. Ed. 2d 407 (1992) (Scalia, J., concurring in judgment in part and dissenting in part). The contrary notion – that express pre-emption provisions must be construed narrowly – was "extraordinary and unprecedented" when this Court announced it two decades ago, *id.*, at 544, 112 S. Ct. 2608, 120 L. Ed. 2d 407, and since then our reliance

> on it has been sporadic at best, *see Altria Group, Inc. v. Good*, 555 U. S. 70, 99-103, 129 S. Ct. 538, 172 L. Ed. 2d 398 (2008) (Thomas, J., dissenting).

CTS Corp. v. Waldburger, 134 S. Ct. 2175, 2189 (2014) (Scalia, J., concurring, and joined by Roberts, C.J., and Thomas and Alito, J.J.). Justice Kennedy has added that the notion of a presumption against preemption from prior express preemption case law is better thought of "not as a presumption but as a cautionary principle to ensure that pre-emption does not go beyond the strict requirements of the statutory command." *Ariz. v. Inter Tribal Council of Ariz., Inc.*, 133 S. Ct. 2247, 2261 (2013) (Kennedy, J., concurring).

Evidencing the point that application of a presumption against express preemption has been sporadic, the Court has regularly, even in the time roughly contemporaneous to *Travelers* and since then, decided express preemption cases without mentioning any such presumption. In this competing body of case law, the Court has treated the question of express preemption as "one of statutory intent, and [the Court] begin[s] with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose." *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 383 (1992) (internal quotation marks and citation omitted); *accord Sprietsma v. Mercury Marine*, 537 U.S. 51, 62-63 (2002); *see generally Northwest, Inc. v. Ginsberg*, 134 S. Ct. 1422, 1429-33 (2014) (finding express preemption with no reference to any presumption against preemption).

Even if a presumption against preemption did fit other statutory regimes with express preemption

provisions, the Court should eschew it for ERISA. The Court – also in the time since *Travelers* – has clarified that judge-made presumptions are especially unsuited for a comprehensive, highly-reticulated statute like ERISA. For instance, in *Fifth Third Bancorp v. Dudenhoeffer*, 134 S. Ct. 2459, 2463 (2014), the Court considered "whether, when an [employee stock ownership plan ('ESOP')] fiduciary's decision to buy or hold the employer's stock is challenged in court, the fiduciary is entitled to a defense-friendly standard that the lower courts have called a 'presumption of prudence.'" The Court rejected such a presumption upon reviewing the statutory provisions concerning fiduciary conduct, finding they "make[] no reference to a special 'presumption' in favor of ESOP fiduciaries." *Id.* at 2467. Similarly, in *M&G Polymers USA, LLC v. Tackett*, 135 S. Ct. 926, 935 (2015), the Court rejected a "presumption" (previously applied by the Sixth Circuit) favoring the vesting of retiree health benefits in collective-bargaining situations. Because ERISA's terms give employers "large leeway to design disability and other welfare plans as they see fit," the ERISA plans "should be enforced as written," subject only to "ordinary principles of contract law." *Id.* at 933 (internal quotation marks omitted); *see also Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 831 (2003) (rejecting presumption favoring views of treating physician in the processing of health-benefit claims, because "[n]othing in the Act itself . . . suggests that plan administrators must accord special deference to the opinions of treating physicians").

Whereas in these other ERISA situations the Court was unwilling to add presumptions unmentioned in the text of the specific ERISA provisions at issue, the Court in *Travelers* did the opposite: it cre-

ated a presumption on preemption nowhere referenced in ERISA's express preemption clause. Consistent with the Court's more recent rejection of interpretive devices unmoored in ERISA's actual terms, ERISA's express preemption regime too should be "shorn of presumptions." *M&G Polymers*, 135 S. Ct. at 927 (Ginsburg, J., concurring).

Not only is a presumption against ERISA express preemption in tension with the Court's other preemption and ERISA case law, it was, respectfully, from the start contrary to Congress's original intent with regard to § 1144(a). As Respondent's brief ably demonstrates in its thorough review of ERISA's legislative history (*see* Resp. Br. 17-23), Congress did not in 1974 have in mind the sort of narrow preemption when it comes to ERISA that a presumption against preemption implies. To the contrary, the Court has characterized ERISA's preemption section on numerous occasions as "clearly expansive," having "a broad scope," having "an expansive sweep," "conspicuous for its breadth," "deliberately expansive," and "broadly worded." *Dillingham*, 519 U.S. at 324 (referencing Court's statements in earlier precedents) (internal quotation marks and citations omitted); *see also Egelhoff*, 532 U.S. at 146. When a provision in a statute is characterized by Congress and this Court alike as the statute's "'crowning achievement,'" as ERISA's preemption clause has been described, it makes little sense *to begin* analysis of whether the provision operates in a particular situation with an approach that all doubts shall be resolved against the provision's application. *Shaw*, 463 U.S. at 99 (quoting 120 Cong. Rec. 29,197 (1974) (statement of Rep. Dent)).

3. *Travelers*'s instruction to focus the express preemption inquiry on ERISA's purposes (at least when applying the "connection with" language) likewise artificially constricts the power of § 1144(a). Again, under *Travelers*, courts look to "'the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive,' as well as to the nature of the effect of the state law on ERISA plans." *Dillingham*, 519 U.S. at 325. True enough, a court should refrain from woodenly applying a preemption clause, without regard to its purposes. But *Travelers*'s focus on the statutory objectives has had a tendency to conflate ERISA express preemption with ordinary conflict preemption. Since at least 1941, the Court has enforced a conflict preemption standard whereby a state law is supplanted by federal law if the state enactment "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941); *accord Geier v. Am. Honda Motor Co.*, 529 U.S. 861, 881-82 (2000). In language reminiscent of *Hines*, the Court in *Travelers* found a New York law exacting surcharges on certain types of commercial insurance to escape preemption, because "cost uniformity was almost certainly not an object of [ERISA] pre-emption." 514 U.S. at 662.

The problem with transforming ERISA express preemption simply into an examination of whether the application of state law would upset Congress's ERISA objectives is that it makes § 1144(a) superfluous. That is, the *Hines* conflict preemption standard existed prior to ERISA and applies in any federal statutory context, irrespective of whether it has an express preemption provision. It therefore would apply in the ERISA context, even absent Congress's

enactment of § 1144(a). Yet, Congress still enacted ERISA's express preemption clause, showing it wanted something more. While relegating a statutory provision to the category of surplussage is never favored, it should truly be anathema for ERISA's express preemption provision, where we know Congress intended the section to be key to the legislation and even revolutionary for its time. *See Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 263 U.S. 1, 24 n.26 (1983) (describing § 1144(a) as a "virtually unique pre-emption provision").

Adding further to the funneling of most ERISA preemption cases into a conflict preemption framework was the Court's simultaneous diminishment of the "reference to" standard for determining when a law "relates to" employee benefit plans. Earlier, the "reference to" prong had a greater scope (*see infra* p. 16); however, *Travelers* and *Dillingham* appeared to limit that part of the test to state laws that name ERISA plans as their "exclusive" subject. *See Dillingham*, 519 U.S. at 325. It is a rare instance where a state passes a law that seeks to regulate ERISA plans, and just them, given the long history of substantial preemption. Consequently, by constricting the reach of the "reference to" test, the Court left nearly all express preemption issues to be determined under the more conflict-preemption-oriented approach associated with the "connection with" strand.

4. *Travelers* also has not, as might have been hoped, ushered in an era of predictable, consistent lower court decisions on ERISA preemption questions. On significant issues, the lower courts – all espousing to apply dutifully *Travelers*'s teachings – have reached opposite conclusions on similar state

laws. *Compare Pharm. Care Mgmt. Ass'n v. D.C.*, 613 F.3d 179 (D.C. Cir. 2010) (finding that ERISA preempts District of Columbia law regulating contracts with pharmacy benefit managers) *with Pharm. Care Mgmt. Ass'n v. Rowe*, 429 F.3d 294 (1st Cir. 2005) (rejecting preemption for similar Maine law); *compare Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 183 (4th Cir. 2007) (finding that ERISA preempts Maryland law requiring specific level of employer expenditures for employee health benefits) *with Golden Gate Rest. Ass'n v. City & Cnty. of San Francisco*, 546 F.3d 639 (9th Cir. 2014) (finding similar local California ordinance not to be preempted); *compare America's Health Ins. Plans v. Hudgens*, 742 F.3d 1319 (11th Cir. 2014) (holding that ERISA preempts Georgia's claims prompt-payment law as applied to self-funded ERISA plans) *with Aetna Life Ins. Co. v. Methodist Hosps. of Dallas*, No. 3:14-cv-347-M, 2015 U.S. Dist. LEXIS 26455 (N.D. Tex. Mar. 4, 2015) (finding no preemption for similar Texas law), *appeal pend'g*, No. 15-10210 (5th Cir. filed Mar. 17, 2015).

One reason that *Travelers* results in unpredictability is that purposes-oriented preemption (as under *Hines*) can sometimes turn into a "'freewheeling judicial inquiry into whether a state statute is in tension with federal objectives,'" rather than "an inquiry into whether the ordinary meanings of state and federal law conflict." *Bates v. Dow Agrosciences L.L.C.*, 544 U.S. 431, 459 (2005) (Thomas, J., concurring in part and dissenting in part) (quoting *Gade v. Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 111 (1992) (Kennedy, J., concurring)); *accord Geier*, 529 U.S. at 911 (Stevens., J., dissenting) (criticizing *Hines* preemption as not "a matter of precise statutory construction," but "an exercise in free-form judicial policy-

making") (internal quotation marks, citation, and alteration omitted).

Another reason that *Travelers* has not brought order to the ERISA preemption arena is that it failed to solve the "difficulty of defining [the express preemption section's] key term." *Travelers*, 514 U.S. at 656. *Travelers* exchanged defining terms such as "relates to," has "connection with," or makes "reference to" employee benefit plans with inquiries into whether a state law concerns "employee benefit plan structures" or "administration," with state laws falling within the scope of the latter terms being on the *Travelers* shorthand list of suspect state measures. *Id.* at 658. "Structures" and "administration" are not precise terms, as the majority and dissenting opinions in Second Circuit in this case illustrate. *See* Pet. App. 29 n.13 ("The dissent draws a 'distinction between general administration and administration of plans, claims, and benefits . . . .'") (citation omitted); *see also Golden Gate Rest. Ass'n*, 546 F.3d at 657 (finding that impermissible requirements regarding administration must mean the "administrative [or] financial burden of complying with conflicting directives relating to benefits law") (internal quotation marks and citation omitted).

B. *The Court Should Revise Its § 1144(a) Standards to Eliminate the Presumption Against Preemption and to Revive a More Potent "Reference to" Analysis*

Travelers was not the cure, and the Court should use this case to bring greater predictability and order to the ERISA express preemption area. It first should discard the presumption against preemption, consistent with the Court's developing general jurisprudence critical of such a presumption in express

preemption contexts and with its ERISA case law rejecting judge-made presumptions for construing ERISA statutory terms. Instead, the Court should "interpret[] the statute without reference to the presumption or any perceived need to impose a narrow construction on the provision in order to protect the police power of the States." *Altria Group, Inc. v. Good*, 555 U.S. 70, 101 (2008) (Thomas, J., dissenting, and joined by Roberts, C.J., and Scalia and Alito, J.J.). Where "an express pre-emption clause" exists, the courts' "task of statutory construction must in the first instance focus on the plain wording of the [express preemption] clause, which necessarily contains the best evidence of Congress' pre-emptive intent"). *Sprietsma v. Mercury Marine*, 537 U.S. 51, 62-63 (2002) (internal quotation marks and citation omitted).

Of course, § 1144(a)'s text has been a source of frustration for the Court, and it therefore would not do much good to re-focus the statutory analysis away from a presumption and to the text, unless some greater clarity can now be ascribed to "relate to." To that end, one substantial improvement the Court could make would be to resuscitate the "reference to" prong of the "relate to" test. In *Travelers* and *Dillingham*, the Court appeared to relegate (or at least the lower courts have assumed as much) a "reference to" finding principally to state laws that target exclusively ERISA plans, an uncommon occurrence. *See supra* p. 6. But that was not always the case. In *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), the Court found a Pennsylvania anti-subrogation law preempted under the following reasoning:

> Pennsylvania's antisubrogation law has a "reference" to benefit plans governed by ERISA.

> The statute states that "in actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to . . . benefits paid or payable under section 1719." 75 Pa. Cons. Stat. § 1720 (1987). Section 1719 refers to "any program, group contract or other arrangement for payment of benefits." These terms "include, *but [are] not limited to*, benefits payable by a hospital plan corporation or a professional health service corporation." § 1719 (emphasis added).

FMC Corp., 498 U.S. at 59 (emphasis and alterations in original).

In *FMC Corp.*, then, the Court found that a state law made "reference to" ERISA plans because it addressed benefits and contracts for benefits and contained language extending its reach to benefits payable from a private employee benefit plan (*i.e.*, by not limiting itself solely to non-ERISA employee benefit plan situations). *Cf. Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987) (finding that contract and tort state law causes of action "undoubtedly meet the criteria for pre-emption under § 514(a)" because "each [was] based on alleged improper processing of a claim for benefits *under an employee benefit plan*") (emphasis added). The Pennsylvania law did not work exclusively on ERISA plans, but operated on an enumerated field that encompassed ERISA plans and did not seek to exclude them.[2]

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[2] *FMC Corp.*'s test that a state law references ERISA plans when it includes ERISA plans *among* its objects is more consistent with § 1144(a)'s text than is the *Travelers-Dillingham* notion that the state law must reference *exclusively* ERISA plans. After all, "reference to" is a construction of "relate to" in

Some ease and predictability could be added to the ERISA express preemption area, were the Court to return to a test whereby a state law makes "reference to" ERISA plans if it overtly mentions employee benefit plans, employee benefits, or the entities inextricably tied to employee benefit plans – such as third-party administrators or pharmacy benefit managers – as among its objects, even if they are not the sole objects of the state legislation. The test would be easy to apply, because courts could refer to the face of the state measure to determine if it names employee benefit plans or the actors associated with employee benefit plans. There would be predictability, since there would be facial analysis of statutory text, not the less precise gleaning of the purposes of ERISA and weighing of whether the state law frustrates or otherwise too negatively impacts those purposes.[3]

Under a strengthened "reference to" standard, Vermont's APCD law would be preempted – easily.

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the statute, and the statute does not provide that state laws are preempted if they "relate *only or solely* to any employee benefit plan" but simply if they "relate to any employee benefit plan."

[3] Laws of general application that regulate businesses or the public generally, and thus for that lone reason include ERISA plans among their regulated entities, would not be preempted under the invigorated "reference to" test. It is laws that overtly take aim at employee benefit plans or those who administer them that would be superseded. Hence, a general garnishment statute would not be preempted, but a state law that sets forth procedures specifically for the garnishment of fringe benefits would be. *See generally Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 831-32 (1988). Similarly, a general sales tax would not be preempted, but a state tax on the processing of benefit claims would be. *But see Self-Ins. Inst. of Am., Inc. v. Snyder*, 761 F.3d 631 (6th Cir. 2014), *pet. for cert. pend'g*, No. 14-741 (filed Dec. 18, 2014).

In brief, it mentions among the objects it brings under its control private-employer employee benefit plans. The implementing regulations for Vermont's statute make this obvious. In the regulations, Vermont extends the reporting law to "any *administrator* of an insured, self-insured, or publicly funded *health care benefit plan* offered by public and *private* entities." Vt. Reg. H-2008-01, § 3(X) (Pet. App. 112-13) (emphasis added). By extending its operation to those who administer employee benefit plans governed by ERISA (whether they are insured or self-funded), the state law refers to ERISA plans. In sum, the preemption analysis under § 1144(a) could begin and end with the text of that one Vermont regulation.

Finally, even with an updated "reference to" test, there would remain for state laws surviving that test the hurdle of avoiding a "connection to" ERISA plans, with the attendant complications of making preemption determinations under the *Travelers* approach. But at least the "reference to" test would mean that, in many instances, a simpler methodology focused on the text of the state law, as well as the text of § 1144(a) (*i.e.*, with "relate to" meaning "reference to"), would govern the preemption outcome. Moreover, the elimination of the presumption against preemption even for "connection with" analysis would remove the "tip[ping of] the scales in favor of the States and against the Federal Government," in a situation where Congress emphasized the primacy of federal interests by enacting a broad preemption provision. *Bates v. Dow Agrosciences L.L.C.*, 544 U.S. 431, 457 (2005) (Thomas, J., concurring in part and dissenting in part, and joined by Scalia, J.).

II. THE VERMONT LAW IS EXPRESSLY PREEMPTED UNDER EXISTING § 1144(a) STANDARDS

A. *Under Current Law, ERISA Expressly Preempts the Vermont Law Due to Its Interference with Congress's Desire for Uniformity in Reporting*

Even without any revision to the regime ushered in by *Travelers*, Vermont's APCD law cannot survive ERISA express preemption. After *Travelers*, a state statute that interferes with ERISA's objectives "relates to" – in particular, has a "connection with" – ERISA plans under § 1144(a) and, therefore, is preempted. *See Travelers*, 514 U.S. at 653; *see also Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) ; *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813-14 (1997); *Dillingham*, 519 U.S. at 325. One of ERISA's oft-repeated chief aims was to ensure uniform, and thus exclusively federal, regulation on core subjects covered by ERISA, and that includes reporting. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137 (1990) (ERISA "sets various uniform standards, including rules concerning reporting, disclosure, and fiduciary responsibility"). The underpinning for uniformity is straightforward: "Requiring ERISA administrators to master the relevant laws of 50 States" – whether on reporting or other areas addressed in ERISA – "would undermine the congressional goal of 'minimizing the administrative and financial burdens' on plan administrators – burdens ultimately borne by the beneficiaries." *Egelhoff*, 532 U.S. at 149-50 (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)).

Indeed, the situation prior to ERISA's enactment, where states had control over reporting with respect

to employee benefit plans proved unworkable. ERISA's reporting and disclosure requirements superseded the Welfare and Pension Plans Disclosure Act ("WPPDA"), 72 Stat. 997 (1958). The WPPDA did not authorize the Labor Department to prescribe the "'form and detail'" of reporting but permitted states to regulate such reporting, which resulted in "administrative chaos." Administration Recommendations to the House and Senate Conferees on H.R. 2 to Provide for Pension Reform, at 88 (Apr. 1974), *reprinted in* Staff of S. Subcomm. on Labor of Comm. on Labor & Pub. Welfare, 94th Cong., Vol. III, Legislative History of [ERISA] of 1974, at 5131 (Comm. Print Apr. 1976) [hereinafter "Comm. Print"]. With ERISA, Congress repealed the WPPDA and replaced it with simple, uniform reporting requirements "consolidate[d] . . . into a single report." *Id.* at 83, Comm. Print at 5126. It did so not solely as a matter of administrative convenience for the federal government; Congress believed it was "essential" to "minimize the burdens placed on plan administrators by . . numerous reporting requirements." *Id.*; *see generally Malone v. White Motor Corp.*, 435 U.S. 497, 505, 512 (1978).

Thus, because a state law conflicting with ERISA's objectives fails under § 1144(a), and one of ERISA objectives, in turn, is uniformity in requirements for reporting by ERISA plans, ERISA would expressly preempt Vermont's law if the law frustrates the attainment of nationally uniform ERISA-plan reporting standards. Respondent's brief (as with the Second Circuit's decision) more thoroughly illustrates that Congress intended reporting on ERISA plans to be a core ERISA subject matter, and likewise intended uniformity in the subject matter.

Resp. Br. 17-24. And it also shows how the Vermont law breaches those standards. *Id.* at 24-47.

The *amicus* wishes (in the sections below) to expand on two points key to the preemption analysis, on which the *amicus* – as an association of entities that administer or insure health benefits for nearly one-third of all Americans – is uniquely positioned to contribute: (1) the extent to which reporting of specifically *medical claims data* is a core matter within ERISA's confines; and (2) the heavy burdens placed on ERISA administrators and insurers by APCD laws, particularly disparate APCD state laws applicable to multi-state ERISA plans. Both points enhance further the case for express ERISA preemption under currently governing standards.

B. *ERISA Requires Detailed Reporting Concerning Medical Claims Data and Similar Information, and the Vermont Law Undermines the Exclusivity of Those Requirements*

1. ERISA's reporting obligations extend to medical claims information for self-funded and insured ERISA plans. Most recently, with the passage of the Patient Protection and Affordable Care Act ("ACA") and subsequent related legislation, Congress instructed additional reporting requirements for health plans covered by ERISA. Through portions of the Public Health Service Act ("PHSA"), 42 U.S.C. §§ 300gg *et seq.*, which are *expressly incorporated into ERISA*, group health plans (including self-insured plans) and health insurance issuers that insure group health plans within ERISA's scope are required to report information concerning the cost and quality of health care. *See* FAQs About Affordable Care Act Implementation (Part XV) (Apr. 29, 2013) ["ACA FAQs"], http://www.dol.gov/ebsa/faqs/faq-aca

15.html. ERISA's incorporation provision states: "the provisions of part A of Title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, *as if included in this subpart.*" 29 U.S.C. § 1185d(a)(1) (emphasis added).

Specifically, under what are known as the PHSA's "transparency" in coverage provisions – again, as incorporated into ERISA – group health plans and health insurance issuers must submit information to the Departments of Health and Human Services ("HHS"), Labor, and Treasury (collectively, the "Departments") and the relevant state insurance commissioner about:

i) Claims payment policies and practices

ii) Periodic financial disclosures

iii) Data on enrollment

iv) Data on disenrollment

v) Data on denied claims

vi) Data on rating practices

vii) Cost-sharing and payment for out-of-network coverage

viii) Enrollee and participant rights

ix) Other information as determined appropriate by the [Departments].

42 U.S.C. §§ 18031(e)(3)(A), 300gg-15a; ACA FAQs at Q3, http://www.dol.gov/ebsa/faqs/faq-aca15.html.

The transparency provisions took effect in 2010, but the Departments have provided notice that they will not require compliance with the provisions until a later date to be set by them, after notice-and-

comment rulemaking regarding the provisions' requirements.[4] The Secretary of Labor, in turn, is tasked with "updat[ing] and harmoniz[ing] the Secretary's rules concerning the accurate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, and periodic financial disclosure with the standards established" by the Departments under the transparency provisions. 42 U.S.C. § 18031(e)(3)(D); *see also* ACA FAQs at Q4, http://www.dol.gov/ebsa/faqs/faq-aca15.html ("the Departments will coordinate regulatory guidance on the transparency in coverage standards").[5]

Also under the ACA-related PHSA provisions incorporated into ERISA, the Departments, "in consultation with experts in health care quality and stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and

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[4] *See* ACA FAQs at Q4, http://www.dol. gov/ebsa/faqs/faq-aca15.html; *see also* HHS, Agency Information Collection Activities: Proposed Collection, Comment Request on Transparency Reporting Provisions, 80 Fed. Reg. 48320 (Aug. 12, 2015); DOL, FAQs about Affordable Care Act Implementation (Part XXVIII) (Aug. 11, 2015), http://www.dol.gov/ebsa/faqs/faq-aca28.html.

[5] The United States notes that the Department of Labor is "currently considering a rulemaking to require health plans to report more detailed information about various aspects of plan administration, such as enrollment, claims processing, and benefit offerings." U.S. *Amicus* Br. 3-4. Just because rules have not yet been finalized does not mean the states can act in the meantime. *See Guss v. Utah Labor Relations Bd.*, 353 U.S. 1, 10-11 (1957) (holding that the States are not free to regulate conduct in areas that Congress has decided require national uniformity through federal preemption, even when "federal power has been delegated but lies dormant and unexercised") (internal quotation marks and citation omitted).

health care provider reimbursement structures." 42 U.S.C. § 3300gg-17(a)(1); *see* 29 U.S.C. § 1185d(a). Additional reporting is required (again as part of the PHSA provisions incorporated into ERISA) for insurers of ERISA plans, which must submit reports to HHS concerning the percentage of premium revenue that they spend on claims for group health plans they insure. 42 U.S.C. § 300gg-18.

These recent additions to ERISA's reporting requirements fortify that reporting – indeed, detailed reporting about claims, eligibility, and other aspects of welfare benefit plan experience – is and remains a core ERISA concern. And to boot, there are additional preemption terms that cover these new reporting requirements and that re-confirm the preemptive force under § 1144(a) of the requirements. In 29 U.S.C. § 1191(a), Congress provided:

> (1) Subject to paragraph (2) . . . this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.
>
> (2) Nothing in this part shall be construed to affect or modify *the provisions of section 1144 of this title* with respect to group health plans.

29 U.S.C. § 1191(a)(1)-(2) (emphasis added). Hence, § 1191 instructs – in subsection (a)(2) – that substantive provisions in this part of ERISA, including the transparency requirements added from the PHSA

and ACA, enjoy the usual ERISA preemptive power vested through § 1144. Subsection (a)(1) additionally instructs that Congress's decision to regulate in the insurance areas covered in this part of ERISA should not be read as an effort to upend the usual protection for state law afforded by the insurance savings clause, 29 U.S.C. § 1144(b)(2)(A), unless the state law establishes standards for health insurers that prevent the application of – *i.e.*, conflict with – this part of ERISA.[6]

2. The Vermont law is preempted under § 1144(a) because it undermines ERISA's aim for uniform, and thus exclusively federal, reporting. ERISA's reporting obligations include – particularly as a result of ERISA's incorporation of the PHSA transparency standards via the ACA – reporting on medical claims and other welfare plan data. Concurrently with ERISA reporting requirements, the Vermont law establishes a database to determine health care resources, needs, policy, quality, and cost. *See* Vt. Stat. Ann. tit. 18, § 9410. Under the state law, ERISA plans and their insurers must report a broad range of data, including claims and enrollment information and "any other information relating to

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[6] State law requirements, such as Vermont's, requiring reporting on claims and other medical data would not constitute saved state insurance regulations, since they do not "substantially affect the risk pooling arrangement between the insurer and the insured." *Ky. Ass'n of Health Plans v. Miller*, 538 U.S. 329, 342 (2003). In reality, APCD laws have nothing to do with risk-pooling at all, just reporting, and therefore are preempted under § 1144(a) both for self-funded and insured ERISA plans. But § 1191(a)(1) still plays an important role, because there are other provisions in this part of ERISA besides transparency, such as benefit mandates, that do implicate the insurance savings clause. *See, e.g.*, 29 U.S.C. §§ 1182-83 (mandating certain mental health and mastectomy coverage).

health care costs, prices, quality, utilization, or resources required by the Board," in an electronic format. *Id.* § 9410(c)(3), (h). Viewed in light of the PHSA transparency requirements codified in ERISA, Vermont's reporting scheme – as noted in the chart below – attempts to foist a detailed, burdensome layer of reporting on ERISA plans that is sometimes overlapping with, and sometimes additional to and conflicting with, the federal system (with rough counterparts side by side below):

Information Required by ERISA, 29 U.S.C. § 1185a, by incorporating 42 U.S.C. §§ 300gg-15a, 18031(e)(3)(A)	***Information Required by Vt. Stat. Ann., tit. 18, § 9410 and Reg. H-2008-01, Vt. Code R. ("Reg. H")***
Claims payment policies and practices (42 U.S.C. § 18031(e)(3)(A)(i))	Health insurance claims and enrollment information (§ 9410(c)(1); Reg. H, §§ 4, 5)
Periodic financial disclosures (42 U.S.C. § 18031(e)(3)(A)(ii))	(No counterpart)
(No counterpart)	Information relating to hospitals (§ 9410(c)(2))
Data on enrollment (42 U.S.C. § 18031(e)(A)(iii))	Member eligibility data relating to health care provided to Vermont residents and health care provided by Vermont health care providers and facilities to both Vermont residents and non-residents

	(§ 9410(h)(1)(A); Reg. H, § 5(A)(9))
Data on disenrollment (42 U.S.C. § 18031(e)(3)(A)(iv))	(No counterpart)
Data on denied claims (42 U.S.C. § 18031(e)(3)(A)(v))	Data on paid claims (§ 9410(h)(1)(B); Reg. H, § 4(A), (D), 5(A))
Data on rating practices (42 U.S.C. § 18031(e)(3)(A)(vi))	(No counterpart)
(No counterpart)	Subscriber information necessary to determine third-party liability for benefits provided (§ 9410(h)(1)(C))
Cost-sharing and payment for out-of-network coverage (42 U.S.C. § 18031(e)(3)(A)(vii))	Co-insurance and co-payment information (Reg. H, § 4(A)(6))
(No counterpart)	Coordination of benefit claim information (Reg. H, § 4(A)(7))
Enrollee and participant rights (42 U.S.C. § 18031(e)(3)(A)(viii))	(No counterpart)
(No counterpart)	Pharmacy claim information (Reg. H, § 5(A)(14)-(15))
Other information as determined appropriate by the Departments (42 U.S.C.	Other information relating to health care costs, prices, quality, utilization, or resources

§ 18031(e)(3)(A)(ix))	required by the Board (§ 9410(c)(3))
Timing and manner of reporting to be developed through coordination among Departments (45 C.F.R. § 156.220(b); ACA FAQs at Q4)	Information for ERISA plans with 2000 or more participants must be submitted *monthly*; 500 to 1999 participants *quarterly*; and 200 to 499 participants *annually* (Reg. H, § 6(I))

As the chart evinces, Vermont's reporting law treads on the area covered by ERISA's reporting requirements, not only duplicating federal requirements but also supplementing and conflicting with them by requiring significant additional information and imposing a rigid reporting schedule not required under federal law. Yet, ERISA was designed "to establish the regulation of employee welfare benefit plans 'as exclusively a federal concern.'" *Travelers*, 514 U.S. at 656 (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)). A nationally "uniform administrative scheme" on reporting cannot possibly exist if Vermont's law, along with similar laws existing in other states, add to ERISA's national reporting requirements. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). On the basis of this interference with ERISA's objective for uniformity in the core area of reporting for employee benefit plans, including reporting concerning medical claims data, the Vermont statute is preempted under § 1144(a).

C. *The Heavy Administrative Burdens Created by the Vermont Law, Particularly for Multi-State ERISA Plans, Highlight the Need for Preemption*

Preemption here is necessarily enhanced, as the Second Circuit held, by the significant burden of complying with differing state APCD laws. *See Egelhoff v. Egelhoff*, 532 U.S. 141, 151 (2001) (buttressing preemption holding with finding that "the burden [of compliance with the state law] . . . is hardly trivial"). Petitioner casually dismisses the Court of Appeals's finding that the burden created by compliance with divergent laws of this genre is "intolerable." Pet. App. 25. In this regard, Petitioner assumes that those administering ERISA plans, including the BCBSA Member Companies as third-party administrators to self-funded plans and insurers of insured ERISA plans, already collect the data necessary to meet each state's reporting requirements, *see* Pet. Br. 23, 52-55, and that it is as simple as pushing a few buttons to transmit the required data to any number of states. *Id.* at 55 ("Reams of information may be transmitted with a few key strokes."). In our experience, however, compliance with state reporting requirements like Vermont's can be just as time-consuming, frustrating, and resource-intensive as the Court of Appeals determined.

Typically, a substantial majority of a BCBSA Member Company's business is private-employer based and, therefore, subject to ERISA. In administering that significant portion of its business, then, the BCBSA Member Company – if APCD laws were not preempted by ERISA – must comply not only with federal reporting obligations under ERISA to which the ERISA plan is subject, but also potentially

with reporting requirements of any states where an employer with whom the BCBSA Member Company contracts has employees, as many of these laws purport to have extra-territorial reach. Notably, Vermont's law does not require reporting only from third-party administrators or insurers stationed in Vermont, but from an entity – seemingly anywhere – that processes or insures benefits for a Vermont resident. *See* Vt. Stat. Ann., tit. 18, § 9410(b). The prospect is that a very large employer with employees in every state – or the third-party administrator or insurer with whom the employer contracts – must comply with fifty states' different APCD laws. And sometimes it must comply with two or more states' laws for the same data, such as when one state requires data about its residents' claims wherever incurred, and the state where the claims were incurred requires reporting on all claims in the state, irrespective of whether the recipient is a resident.

It is burdensome to respond to a single state's APCD law. In BCBSA Member Companies' experience, it is not uncommon that, once such a law has been enacted, a full-court press is required initially to create and bring "on line" the systems necessary for compliance. It can require the work of multiple full-time employees as well as hundreds of additional employee hours to wade through technical issues with the state's data vendor and through legal issues with state regulators. And once reporting begins, the compliance systems do not continue forward on autopilot; there is an ongoing burden to keep the data reporting system up and running. To comply with a single state law, this can require several full-time employees on an open-ended basis, as well as signifi-

cant financial outlays associated with support provided by outside vendors.[7]

One major, and time-consuming, complication often encountered is the seemingly arbitrary percentage-based "thresholds" set by state laws for how many claims files must contain a particular data element, in order for the files to avoid a finding of noncompliance. States can require, for instance, that third-party administrators and insurers report who recommended admission to a medical facility. If the healthcare provider does not include that information when submitting his or her claim to the ERISA plan administrator or insurer, then the entity doing the reporting will not have the data. If the state sets a minimum threshold requiring that at least 50% of all claim files submitted to the state by that entity must include that data, the entity might not meet the reporting threshold. And if it does not meet the threshold, the entity must devote additional time and resources to seeking variances from the

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[7] For example, Vermont specifies in detail the file format and other technical requirements necessary for data submission. *See* Vt. Reg. H-2008-01, §§ 6, 7. The technical systems, therefore, must be developed to allow for the reporting of the requested data. Before data can even be submitted, the reporter must submit a test file to ensure compliance. *See id.* § 6(E). Thereafter, if a data file does not conform, it must be corrected and resubmitted within ten days. *See id.* The same scenario can replicate itself in other states where the reporter must likewise report for data subject to that jurisdiction's APCD law. And the tasks are made even more complicated and time-consuming because the reporter must additionally scrub data to comply with overriding federal directives, such as the federal Substance and Alcohol Abuse statute. *See* 42 C.F.R. pt. 2.

state – for data that the healthcare provider simply never supplied.[8]

Further complications arise due to a lack of uniformity among the states as to the data they require, the format in which it must be reported, and the frequency with which it must be transmitted. Time and resources are required just to track which states have reporting laws and determine whether compliance is required, and then to implement and run the necessary programs. Over time, state reporting requirements also change, adding to the expense.

To be sure, BCBSA's Member Companies incur these burdens on a large scale because they are in the business of providing services and products (administrative or insurance-related) to ERISA plans and therefore deal with large swaths of information. But the burdens do not go away when moved from a macro to a micro scale. If anything, they become more acute. Again, Vermont's law applies, under implementing regulations to "any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private enti-

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[8] Another aspect of APCD laws that creates severe difficulties especially for out-of-state entities administering benefits for the reporting state's residents is that the reporting state often requires data on plan features otherwise mandated by the reporting state in its insurance role (*e.g.*, about cost-sharing or copay features, etc.). But the out-of-state entity, if a self-funded ERISA plan, will have created its own benefits array limited only by what federal law mandates; and insured ERISA plans would have followed their own state's benefit mandates. Thus, the state requiring reporting may want information on a topic foreign to the out-of-state entity doing the reporting on Vermont residents. When that box then shows up empty (or below the minimum threshold of anticipated data responses), the report would be rejected, spiraling the endeavor into an effort to explain, and get approval for, variances.

ties." Reg. H-2008-01, § 3(X). Accordingly, a large ERISA plan that is self-administered, and has participants and beneficiaries throughout the country, would face the same systems start-up and ongoing costs of compliance, except for a smaller universe of individuals. The economies of scale that a BCBSA Member Company might enjoy to make compliance more streamlined would be nonexistent in the single ERISA plan situation, with its burden then repeated by other single ERISA plans to the same degree.

CONCLUSION

The Court should affirm the decision of the Court of Appeals.

Respectfully submitted,

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No. 14-181

In The
Supreme Court of the United States

ALFRED GOBEILLE, in his official capacity as chair of the Vermont Green Mountain Care Board,

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

BRIEF OF *AMICUS CURIAE* CONNECTICUT HEALTH INSURANCE EXCHANGE D/B/A ACCESS HEALTH CT IN SUPPORT OF PETITIONER

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INTEREST OF *AMICUS CURIAE*

The Connecticut Health Insurance Exchange d/b/a Access Health CT (the Exchange)[1] is the health insurance exchange for the State of Connecticut. The Exchange is a quasi-public agency tasked with, among other things, the development and operation of Connecticut's all-payer claims database (the APCD). *See* Conn. Gen. Stat. § 38a-1081.

In *Liberty Mutual Insurance Company v. Donegan*, 746 F.3d 497 (2d Cir. 2014), a divided panel of the Second Circuit Court of Appeals held that the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001 *et seq.*, preempts health care data reporting laws, including all-payer claims databases, with respect to self-insured health insurance plans subject to ERISA. The decision of the Court of Appeals is a direct threat to the Exchange's ability to fulfill its statutory mandate and, unless overturned, may act to limit Connecticut's access to

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[1] All parties to this matter have granted blanket consent for the submission of *amicus curiae* briefs in support of either or neither party. The petitioner filed his consent on July 9, 2015, and the respondent filed its consent on July 10, 2015. The requirements of Rule 37.2(a) of the Rules of this Court are satisfied by these filings. In accordance with Rule 37.6, *amicus curiae* affirms that no counsel for a party authored this brief in whole or in part, and represents that no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person or entity other than the *amicus curiae*, its members or its counsel, has made a monetary contribution to the preparation or submission of this brief.

essential health care information. The Exchange maintains that this decision was in error and misapplies ERISA preemption to health care laws in an overly broad manner that threatens the ability of Connecticut to collect health care information for the purpose of improving the quality, efficiency and accessibility of health care services in Connecticut.

SUMMARY OF ARGUMENT

At issue in this case is whether States may require payers of health care services, specifically self-insured health insurance plans governed by ERISA, to provide the State with health care claims data that the State has deemed essential to its efforts to address health care policy and implement health care reform initiatives.

The purpose and history of State APCD efforts reflect that they fall squarely within the legitimate realm of traditional State policing authority in an area that is firmly within the provenance of the States. The crucial State interests at stake in these efforts will be substantially undermined if the decision of the Court of Appeals is upheld.

This Court's decisions on ERISA preemption establish that State efforts to regulate health care through laws of general applicability that do not purport to regulate the structures or core functions of ERISA plans are not preempted by ERISA. The Court of Appeals inappropriately rejected the presumption

against preemption, and its decision manifests a much broader view of preemption that undermines the legitimate health care policy objectives of the States.

ARGUMENT

I. The Connecticut APCD Statute is an Exercise of Connecticut's Traditional Police Power to Address Health Care Issues, and the Decision Below Threatens to Seriously Diminish the Effectiveness of Such Exercise.

A. The Connecticut APCD Statute is a Law of General Applicability that Addresses Health Care Issues.

Connecticut's "all-payer claims database" is a database that "receives and stores data from a reporting entity relating to medical insurance claims, dental insurance claims, pharmacy claims and other insurance claims information from enrollment and eligibility files." Conn. Gen. Stat. § 38a-1091(a)(1). The APCD receives such claims information from, among other entities:

> (A) insurers licensed to do health insurance business in Connecticut;
>
> (B) third-party administrators;
>
> (C) pharmacy benefits managers;

(D) fraternal benefit societies that transact health insurance business in Connecticut;

(E) dental plan organizations;

(F) preferred provider networks; and

(G) "[a]ny other person that administers health care claims and payments pursuant to a contract or agreement or is required by statute to administer such claims and payments." *Id.* § 38a-1091(a)(2)(A).

One key purpose of collecting health care claims data is to allow the APCD to utilize such data "to provide health care consumers in the state with information concerning the cost and quality of health care services that allows such consumers to make economically sound and medically appropriate health care decisions." *Id.* § 38a-1091(b)(4)(A). In addition, the APCD will make de-identified[2] health care claims information available to State agencies, insurers, employers, health care providers, consumers of health care services, and researchers "for the purpose of allowing such person or entity to review such data as it relates to health care utilization, costs or quality of health care services." *Id.* § 38a-1091(b)(4)(B).[3]

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[2] De-identified health care information is information from which all eighteen identifiers enumerated at 45 C.F.R. § 164.514(b)(2) have been removed.

[3] For example, oncology researchers may link claims data with tumor registry data (for cancer stage information) and vital

(Continued on following page)

The APCD may also make such information available for community and public health assessment activities.[4] Thus, health care researchers and policy makers may be granted access to health care claims information to identify disparities, or more specifically, income classes or racial demographic groups lacking access to certain categories or types of health care services. State regulators may be granted access to the information when making health care planning decisions, such as the review of Certificate of Need[5] applications by the Connecticut Department of Public Health.[6] Consumers may be granted access to the health care claims information to compare the

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statistics data (for information on death) currently maintained by the State. This connectivity may contribute to a better understanding of the efficacy of various treatment modalities. Generally, studies of cancer and rare diseases benefit from the use of large underlying population data in order to provide reasonable size for longitudinal studies. If claims data from self-insured plans is excluded, it would limit the ability of researchers to conduct such important studies.

[4] Policies and Procedures: All-Payer Claims Database, Connecticut Health Insurance Exchange, adopted Dec. 5, 2013, available at http://www.ct.gov/hix/lib/hix/DRAFT_AHCT_APCD_Policies_and_Procedures.pdf (accessed Aug. 27, 2015).

[5] In many instances, Connecticut law requires a health care provider to submit a Certificate of Need application to the Department of Public Health prior to opening or closing a facility or service line. Conn. Gen. Stat. § 19a-638.

[6] The Department of Public Health, through its Office of Health Care Access, utilizes the Certificate of Need process as a mechanism to restrain health care facility costs and allow coordinated planning of new health care services and construction. Conn. Gen. Stat. § 19a-639.

costs of receiving a particular treatment or service at various local health care providers. Lastly, the information may be useful in the development of wellness and disease prevention programs.

The APCD also is integral to Connecticut's participation in the State Innovation Model (SIM) program established by the Centers for Medicare and Medicaid Services (CMS). In 2014, CMS awarded Connecticut a four-year, $45 million grant to "test state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries – and for all residents."[7] The APCD has been identified as a key resource for the implementation of this program in Connecticut,[8] and the APCD's inability to receive claims data from self-insured health plans would undermine the success of the program.

The value and importance of the APCD with respect to consumer health care education and the reform of health care in Connecticut with respect to

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[7] SIM Program Management Office, Connecticut State Innovation Model: SIM at a Glance, May 12, 2015, available at http://www.healthreform.ct.gov/ohri/lib/ohri/SIM_at_a_glance_05122015.pdf (accessed Sept. 1, 2015).

[8] Office of the Lieutenant Governor, Connecticut Healthcare Innovation Plan, Dec. 30, 2013, available at http://www.healthreform.ct.gov/ohri/lib/ohri/sim/plan_documents/ct_ship_2013_12262013_v82.pdf (accessed Sept. 1, 2015).

health care utilization, costs, and quality of health care services has been recognized and endorsed by a diverse set of stakeholders in Connecticut's health care community. In public comments, the Connecticut State Medical Society[9] recognized the importance of the APCD in addressing issues of health care access and disparity based upon income, racial or other demographic factors and stated "[d]ata collection is the best means we have to analyze how we as a state are doing when it comes to breaking down racial and ethnic barriers in healthcare."[10] Echoing the Connecticut State Medical Society's emphasis on health care access and disparity, the Connecticut Health Foundation[11] stated that the APCD "has the potential to help answer timely and relevant access, quality, and cost questions about coming health care reforms" and "will be tremendously useful" with respect to the foundation's health equity and integrated care concerns.[12]

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[9] The Connecticut State Medical Society is the professional association for physicians practicing in Connecticut.

[10] Comments on Draft Policies and Procedures: All-Payer Claims Database, Connecticut State Medical Society, Sept. 9, 2013, available at http://www.ct.gov/hix/lib/hix/APCD_Policies_and_Procedures_Public_Comments_-_CT_State_Medical_Society.pdf (accessed Aug. 27, 2015).

[11] The Connecticut Health Foundation is a private foundation working to creating more access to better quality health care for populations of color and underserved communities in Connecticut.

[12] Public Comment, APCD Draft Policies and Procedures and Data Submission Guide, Connecticut Health Foundation, Sept. 3, 2013, available at http://www.ct.gov/hix/lib/hix/APCD_Policies_and_Procedures_Public_Comments_-_CT_Health_Foundation.pdf (accessed Aug. 27, 2015).

Stakeholders have also noted the importance of the APCD to improving the quality of health care in Connecticut. The Connecticut Business & Industry Association[13] noted that the APCD is "a tool that stakeholders throughout the state may utilize to gain information on healthcare costs and quality with the goal of enhancing outcomes and improving efficiency."[14] The State of Connecticut Comptroller[15] referred to the APCD as a "significant and important tool for improving the efficiency and outcomes in our health care system."[16] Similarly, in joint comments, the Connecticut Center for Patient Safety[17] and the Connecticut Health Policy Project[18]

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[13] The Connecticut Business and Industry Association is a statewide business organization.

[14] Comment in Response to Access Health CT's Draft Policies and Procedures: All-Payer Claims Database, Connecticut Business & Industry Association, Sept. 12, 2013, available at http://www.ct.gov/hix/lib/hix/APCD_Policies_and_Procedures_Public_Comments_-_CT_Business_and_Industry_Association.pdf (accessed Aug. 27, 2015).

[15] The State of Connecticut Comptroller is a state agency with responsibility for fiscal and government transparency matters, including affordable and quality health care.

[16] Comments of State of Connecticut Comptroller, Sept. 12, 2013, available at http://www.ct.gov/hix/lib/hix/APCD_Policies_and_Procedures_Public_Comments_-_Comptroller_Kevin_Lembo.pdf (accessed Aug. 27, 2015).

[17] The Connecticut Center for Patient Safety is a nonprofit organization focused on patient safety, the quality of health care services and patient rights.

[18] The Connecticut Health Policy project is a nonprofit research and educational organization working to improve access to affordable, quality health care for Connecticut residents.

noted the potential of the APCD "to improve health care planning, control costs, improve the quality of care, and reduce health disparities."[19]

B. The History of the Connecticut APCD Statute Makes Clear that it Addresses Health Care Issues, and Reflects the Focus of Constituents in the Health Care Industry to Address Health Care Issues.

The history of Connecticut's APCD underlines its purpose as a tool to inform the effective and informed regulation of the health care industry, a traditional and long-accepted role for State government. In 2011, and in response to the passage of the Patient Protection and Affordable Care Act, P.L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152, 124 Stat. 1029, and nationwide efforts to reform the delivery of health care to improve efficiency, quality and utilization, the State of Connecticut created the Office of Health Reform and Innovation (OHRI). *See* 2011 Conn. Acts 11-58 §§ 11, 13. The OHRI was housed in the Office of the Lieutenant Governor and was tasked with coordinating and implementing

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[19] Comments of Connecticut Center for Patient Safety and the Connecticut Health Policy Project, Sept. 10, 2013, available at http://www.ct.gov/hix/lib/hix/APCD_Policies_and_Procedures_Public_Comments_-_Ellen_Andrews_and_Jean_Rexford.pdf (accessed Aug. 27, 2015).

Connecticut's "responsibilities under state and federal health care reform." *Id.* § 13. Among other things, the OHRI was directed to develop "a plan to implement a state-wide multipayer data initiative to enhance the state's use of health care data from multiple sources to increase efficiency, enhance outcomes and improve the understanding of healthcare expenditures in the public and private sectors." *Id.* § 11.

In 2012, the Connecticut General Assembly formally established the APCD, resulting from the "multipayer data initiative." 2012 Conn. Acts 12-166 § 1. This act established the requirements for reporting entities to submit data to the APCD and the uses of the claims data for the benefit of consumers, the State, and other stakeholders as described in Section I.A., above. Responsibility for the establishment and implementation of the APCD was transferred to the Exchange in 2013. 2013 Conn. Acts 13-247 §§ 137, 144. The health care purpose and mission of the program remained unchanged as a result of the transfer.

The Exchange's development and implementation of the APCD has been supported and guided by the All-Payer Claims Database Advisory Group (the Advisory Group). Conn. Gen. Stat. § 38a-1091(c)(1). The Advisory Group is composed of: (i) the Secretary of the Office of Policy and Management; (ii) the Comptroller; (iii) the Commissioners of the Departments of Public Health, Social Services, Mental Health and Addiction Services, and Insurance; (iv) the Healthcare Advocate; (v) the Chief Information

Officer of the State of Connecticut Department of Information Technology; and (vi) representatives of the Connecticut State Medical Society, health insurance companies, consumers, hospitals, consumer advocates and health care providers. *Id.* The purpose of the Advisory Group is to assist the APCD in enhancing the "state's use of health care data from multiple sources to increase efficiency, enhance outcomes and improve the understanding of health care expenditures in the public and private sectors." *Id.* § 38a-1091(c)(2). The Advisory Group meets quarterly to review APCD activities, to provide stakeholder feedback, and to review operating policies and procedures in order to make recommendations to the Exchange's board of directors. The APCD relies upon the Advisory Group members, including representatives of health insurance companies, to improve the effectiveness of the APCD and address stakeholder concerns.

C. The Decision Below may Seriously Diminish the Effectiveness of Connecticut's APCD.

The decision of the Court of Appeals puts at risk Connecticut's APCD and, by implication, Connecticut's health care reform efforts. The decision threatens to weaken one of Connecticut's most powerful tools for reviewing and analyzing health care data and would hamper Connecticut's ability to promulgate evidence-based health care policy and regulation.

The decision is also a threat to health care reform more broadly if it applies to all similar all-payer claims database statutes. At least sixteen States have enacted legislation establishing such health care data programs, and numerous other States have expressed interest in adopting similar programs.[20] This trend reflects the reality that effective health care reform and innovation efforts are predicated on access to accurate and complete data. Affirming the Second Circuit's expansive view of ERISA preemption would result in a firewall being imposed on self-insured health insurance plan claim information. This will have a devastating impact on the States' efforts. In Connecticut, in 2011, 54.4% of workers who obtain health insurance coverage through their employer were enrolled in a self-insured plan, and the percentage of workers enrolled in such plans has continued to grow.[21] In many instances, the data maintained by health plans cannot be obtained from other sources. A decision that prevents health care policymakers and regulators from collecting health care claims information from such a large segment of the population would therefore severely frustrate the continued

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[20] Rebecca Paradis & Erin Bartolini, *All Payer Claims Databases: Unlocking the Potential*, NEHI Issue Brief (Network for Excellence in Health Innovation, Cambridge, MA), Dec. 2014, at 1.

[21] Paul R. Fronstin, *Self-Insured Health Plans: State Variation and Recent Trends by Firm Size*, 33 EBRI.ORG Notes (Employee Benefit Research Institute Educ. & Research Fund, Washington, DC), Nov. 2012, at 1, 6.

movement towards evidence-based health care reform and innovation efforts.

II. The Vermont APCD Statute and Similar State Statutes are not Preempted by ERISA.

The Vermont APCD statute, and similar APCD statutes, including the Connecticut APCD statute, are not preempted by ERISA because they are not State laws that relate to employee benefit plans within the scope of ERISA's preemption clause, 29 U.S.C. § 1144(a).

This Court has held that, despite the "clearly expansive" preemption language employed by ERISA, there remains a presumption that Congress did not intend to supplant State law, particularly where the State is acting within a field of traditional State regulation. *N.Y. Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995). The Court of Appeals rejected this presumption because it held that Vermont's statute did "not regulate the safe and effective provision of health care services." *Donegan*, 746 F.3d at 506 n.8. This view is blind to the goals of APCDs and casts aside the paramount State interest in data collection endeavors, which as seen above with regard to Connecticut's efforts, is directly related to improving quality, enhancing access, and achieving efficiencies in the provision of health care services.

Given the intended purposes of APCD statutes like Vermont's, and as detailed above regarding

Connecticut's efforts, there can be no question but that such APCDs advance the legitimate interests of the States in regulating "matters of health and safety." *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 (1997).

The Court of Appeals concluded that the Vermont law was preempted because it required "reporting," which "is a core ERISA function." *Donegan*, 746 F.3d at 508. In adopting this literal view of the word "reporting," however, the Second Circuit failed to account for the vast difference in context of the ERISA reporting requirements. Instead, it fell victim to the same predicament that this Court identified in *Travelers* when it observed that as a phrase of limitation, the phrase "relate to" in 29 U.S.C. § 1144(a), read literally, was not helpful. *See Travelers*, 514 U.S. at 655 ("If 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course . . . ."). In a similar way, the word "reporting," read literally by the Court of Appeals as "filing with a third party," *Donegan*, 746 F.3d at 508, would put all manner of general purpose health care laws at risk of preemption simply because a third-party filing must be made, regardless of whether it impacted the core concerns of ERISA.

The District Court, in sharp contrast, recognized the importance of context in this Court's ERISA jurisprudence:

> The appropriate question . . . is not the uncritically literal one of whether Vermont's health care database law imposes a reporting requirement on . . . an ERISA plan. It is rather a more contextual one: whether a state data reporting requirement dictates or disrupts the activities or operations of an ERISA plan, or compromises the administrative integrity of an ERISA plan, or in some way creates state oversight of the administration of an ERISA plan.

Liberty Mut. Ins. Co. v. Kimbell, No. 2:11cv204, 2012 WL 5471225, at *12 (D. Vt. Nov. 9, 2012). The District Court went on to conclude, correctly, that the Vermont statute did not dictate benefits or disrupt the activities or operations of an ERISA plan and that it, therefore, was not preempted. *See id.* at *13.

The decision of the Court of Appeals is inconsistent with this Court's approach to preemption in *Du Buono* and *Travelers*. The presumption against preemption in these circumstances should not be overcome where a State law of general applicability does not relate to ERISA plans in any meaningful way, such as by dictating benefits or interfering with plan administration.

The States should be free to pursue their legitimate interests in obtaining the information deemed necessary to regulate and improve the provision of health care services to their citizens and to empower their citizens to actively participate in the health care decision-making process. The decision of the Court of

Appeals, if not reversed, will put at risk the effectiveness of not only the Vermont APCD statute, but all similar APCD statutes.

CONCLUSION

For the foregoing reasons, *Amicus* respectfully urges this Court to reverse the decision of the Second Circuit Court of Appeals.

Respectfully submitted,

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In The
Supreme Court of the United States

ALFRED GOBEILLE, in His Official Capacity as Chair of the Vermont Green Mountain Care Board,

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

BRIEF OF *AMICI CURIAE* HARVARD LAW SCHOOL CENTER FOR HEALTH LAW AND POLICY INNOVATION, ET AL. IN SUPPORT OF PETITIONER

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INTEREST OF *AMICI CURIAE*[1]

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[1] *Amici* submit this brief pursuant to Supreme Court Rule 37.4. Both parties have consented to the filing of *amicus curiae* briefs in support of either party. Pursuant to Supreme Court Rule 37.6, *Amici* state that no counsel for a party authored this brief in whole or in part and that no person or entity other than *Amici*, its members, and its counsel contributed monetarily to the preparation or submission of this brief.

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University School of Public Health.[2] With the exception of CHLPI, which is an academic center devoted to advocating for legal, regulatory, and policy reforms to improve the health of underserved populations, all *amici* hold academic positions within major American universities, study trends within the American health care system, and require reliable health care data to further their research. All *amici* have an in depth understanding of the unique value that State-run all-payer claims databases (APCDs)[3] present for the field of health services research.

Amici write to (1) explain the differences between the information the Employee Retirement Income Security Act of 1974 (ERISA) requires payers to report and the information contained in APCDs; (2) demonstrate the unique importance of state-run all-payer claims databases (APCDs) in furthering health services research and influencing health care policy; and (3) offer this Court a unique insight into the undermining effect that Respondent's proposed interpretation of the ACA would have on the national ability to study health services, which include both clinical care

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[2] Institutional affiliations are provided for identification purposes only. This brief does not purport to present the institutional views, if any, of the named universities.

[3] APCDs are large-scale databases that systematically collect medical claims, pharmacy claims, dental claims, and eligibility and provider files from public and private payers. Thus, in the United States APCDs include data from Medicare, Medicaid, and private insurers. Countries with single payer systems have APCDs that draw solely upon the data of their national system.

as well as macro health care trends such as health care costs, and to inform health care policy.

SUMMARY OF ARGUMENT

The central issue in this case is whether ERISA, 29 U.S.C. § 1001 *et seq.*, preempts state laws requiring all in-state health care payers, including self-funded insurance plans, to report claims and health care services data to the State in order to create an APCD. Specifically, the question at hand is whether ERISA preempts a Vermont statute establishing a unified health care database and requiring health insurers to report health insurance claims, enrollment information, and other information relating to health care costs, prices, quality, utilization or resources to the database. VT. STAT. ANN. TIT. 18 § 9410(a)-(d).

A divided panel of the Second Circuit held that ERISA preempts the Vermont statute and accompanying regulations requiring self-funded insurance plans to report their health care claims data to the Vermont APCD. The Second Circuit's decision was incorrect because it relies on an overly broad and outdated view of ERISA preemption and confuses the financial reporting requirements of ERISA with the type of information that health care payers are required to report to APCDs.

ERISA was not intended to shield self-funded insurance plans from all state regulation. Rather,

ERISA was intended to protect the interests of beneficiaries of employee benefit plans by standardizing certain financial disclosure and reporting requirements, as well as establishing standards of conduct, responsibility and obligation for fiduciaries of these plans. By contrast, APCDs do not concern themselves with the financial soundness of employee benefit plans. Rather, they collect health care claims data intended to evaluate and improve the quality and cost of health care provided in the State. Because ERISA preempts state laws *only* "insofar as they . . . relate to any employee benefit plan," 29 U.S.C. § 1144(a), and because the APCD reporting requirements do not overlap with or undermine compliance with ERISA's financial reporting requirements, the reporting requirements of the Vermont statute should not be preempted by ERISA.

Drawing upon available data from the APCDs is crucial for improving clinical care, addressing health care cost issues, and informing health care policy. Health care claims are one of the primary sources of data for health services research in the United States. Furthermore, State APCDs are the closest resource researchers studying the American system can obtain compared to the national databases and registries available in single payer countries. Relying solely on data from government payer programs, such as Medicare and Medicaid, or from individual insurance companies, can lead to conclusions that are not applicable to all patient populations. APCDs provide researchers the ability to study disease burden,

disease management, health care costs, and treatment effectiveness across the full range of patients within a State. Additionally, APCDs provide community-wide data that allow researchers to improve on the public health status of the community studied, by monitoring concerns such as achieving herd immunity through vaccination or generating policy suggestions to improve population health. APCDs have also been essential to the development and implementation of health policies and to tracking the impact of policy changes on both health and health care. The singular ability of State APCDs to monitor the performance of health care delivery systems within each State underscores that the APCDs' reporting requirements do not relate to ERISA reporting requirements.

Allowing self-funded insurance plans to use ERISA as a shield against reporting their health care claims data would undermine the ability of health care and services researchers to improve the quality of care and to address health care costs and other trends. The universal dataset available from APCDs is important because, although some insurers may be willing to share their data with researchers, health care claims data in fragmented form are less useful than a comprehensive data set and the likelihood of all insurers cooperating to share data without regulation is low. Even if the majority of insurers cooperate to form a health care claims database, it will not deliver comprehensive data to researchers, limiting the usefulness of a private health care claims database. Because of the lack of overlap between the

reporting regimes as well as the important scientific value of the information available through the APCDs, this Court should reverse the judgment of the Second Circuit Court of Appeals.

ARGUMENT

I. The Judgment Below Applies ERISA Preemption in an Overly Broad Manner that is Incompatible with Recent Case Law.

The reporting regimes required by ERISA and by the Vermont statute establishing its APCD have virtually no overlap in their focus and in the type of information they require. Furthermore, because all insurance plans will have this information already aggregated in their own databases, the Vermont statute will not substantially impact how benefits are administered to beneficiaries or mandate certain benefit structures. Therefore, under the standard articulated by this Court in prior cases such as *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, the Vermont statute and its accompanying regulations should not be preempted by ERISA. 519 U.S. 316 (1997).

A. ERISA's Preemption Clause was Intended Only to Prevent Impact to the Administration of Benefits of Employee Benefit Plans.

ERISA regulates employee benefit plans, including self-funded health care insurance plans. In creating ERISA, Congress intended to establish the regulation of such plans, which included self-funded health insurance plans, "as exclusively a federal concern." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981). As this Court previously concluded, "the goal [of ERISA's preemption clause] was to minimize the administrative and financial burden of complying with conflicted directives among States or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law." *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656-57 (1995). To prevent such conflicts, Congress included a preemption provision in ERISA, which this Court interpreted to mean that a State law is preempted if "it has a connection with or reference to such a[n employee benefit] plan." *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 97 (1983).

Nevertheless, this Court has repeatedly cautioned that even in cases "where federal law is said to bar state action in fields of traditional state regulation . . . [the Court has] worked on the 'assumption that the historic policy powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.'"

Travelers, 514 U.S. at 655 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 229 (1947)). Therefore, this Court limited ERISA preemption to only "state statutes that mandate[ ] employee benefit structures or their administration." *Dillingham Constr.*, 519 U.S. at 328 (quoting *Travelers*, 514 U.S. at 658). Because of the limitations upon the preemption provision, ERISA preserves a role for state regulations that do not overlap with or burden compliance with ERISA's requirements or core purposes.

B. ERISA's Core Reporting Requirements Relate Only to Financial Reporting.

The Second Circuit panel noted that reporting was a "core ERISA function[ ] subject to a uniform federal standard." *Liberty Mut. Ins. Co. v. Donegan*, 746 F.3d 497, 505 (2d Cir. 2014). However, the ERISA reporting requirements cover mostly financial information, such as a statement of assets and liabilities, changes in fund balances, disclosures about changes made in the plans, actuarial statements, and certain financial commitments, including loans, leases, and transactions. *See* 29 U.S.C. § 1023. The information reported is used to generate a summary plan description for plan participants and a financial annual report to the Secretary of Labor. *See* 29 U.S.C. § 1021-30.

By contrast, the Vermont statute requiring insurers to report information to the State's APCD asks for very different data. It seeks information on

medical claims data, health services provided to beneficiaries, charges and payments for medical services, and the demographic information of the beneficiaries. VT. STAT. ANN. TIT. 18 § 9410(c)-(d) (Supp. 2014); Reg. H-2008-01, 21-040-021 Vt. Code R. (2008). The Vermont statute is designed to obtain valuable health care claims data, not to investigate the financial soundness of the State's health care plans. As discussed below, claims data, aggregated across all payers, are uniquely valuable in the information they provide on the state of the American health care system. The value of the data further underscores the difference between the reporting requirements found in ERISA and the reporting requirements mandated by the Vermont statute. Fundamentally, the Vermont statute does not actually impact ERISA's core reporting function because it focuses on entirely different data.

Additionally, the Vermont statute asks only for information typically generated in health care encounters and routinely aggregated by health care plans, including self-funded insurance plans in their own administrative databases. *See* Denise Love, William Custer, and Patrick Miller, *All-Payer Claims Databases: State Initiatives to Improve Health Care Transparency*, Commonwealth Fund pub. 1439, Vol. 99 (Sept. 2010). Under the standard articulated in *Dillingham Constr.*, statutes that do not directly relate to an ERISA core function, such as reporting, may still be preempted if the State statute in question impacts how benefits are administered to beneficiaries

or mandates certain benefit structures. 519 U.S. at 319. Because Liberty Mutual in this case and other self-funded insurance plans in general already aggregate this information, the Vermont statute is not onerous enough to dictate benefit structures. Additionally, the reporting requirements are broad enough to encompass a variety of benefit structures, such as traditional fee for service payment and newer forms such as capitated payments. For example, this Court found that ERISA preempted a New York law requiring employers to provide the same benefits for pregnancy-related disabilities as for other disabilities, *Shaw*, 463 U.S. at 85, as well as a state law that revoked, upon divorce, a former spouse's status as a beneficiary, *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001). In both cases, this Court concluded that the regulations required plans to deliver a different package of benefits in the State in question, than in neighboring States. By contrast, in this case, the reporting requirements do not mandate that self-funded insurance plans provide certain benefits, such as providing mental health benefits or benefits to domestic partners. Instead, the reporting requirements only require that the self-funded insurance plans report the health care claims data deriving from the benefits they do offer.

II. APCDs Provide Vital and Unique Data for Health Services Research and Policy Decision Making.

APCDs are an important tool that researchers, including those based at academic medical centers

and universities, use to understand cost, utilization, and quality of health care as well as to generate recommendations regarding health care policy. APCDs function as a useful source of comprehensive claims data for health services research in the United States. Health services research encompasses a broad range of important issues dedicated to improving the American health care system, including cost trends relating to price transparency, hospital, provider, and patient out-of-pocket costs, location and performance of intra-state health care markets, as well as clinical care issues including health status, disease management, pregnancy management, medication safety, hospital quality, and hospital-associated infections. Access to a comprehensive database that includes all claims in an area – not just those from public payer systems or from one or two insurers – permits rigorous efforts designed to rectify or address issues in our health care system for the benefit of patients and the improvement of the broader system.

A. APCDs are Necessary for Supporting Certain Health Services Research and Policy Decision Making.

APCDs are critical for improving the quality of health care interventions in this country, refining health care policy on the local, state, and federal level, and for understanding cost, utilization, and quality of health care. APCDs allow researchers to study a variety of health care issues, including clinical care as well as trends impacting and informing

health care policy. APCDs also provide information in context to researchers, allowing them to observe important phenomena, such as practice variation among regions, through more traditional experiments.

1. APCDs Support a Variety of Important Research

APCDs are an important data source that has been used in a broad variety of health services research that has directly impacted patient care and the provision of health care services. For example, azithromycin, an antibiotic, has historically been considered free of serious adverse effects and safe to use for the treatment of upper and lower respiratory infections and some sexually transmitted infections. In 2012, an American team studying Medicaid data from Tennessee reported that patients using azithromycin had a risk of death from cardiovascular causes that was two to three times higher than the risk of individuals taking amoxicillin – another common antibiotic – or not using antibiotics. Wayne A. Ray et al., *Azithromycin and the Risk of Cardiovascular Death*, New England Journal of Medicine 366 (May 17, 2012). This study could have a serious impact on the standard course of care for common infections and was intended to help physicians and patients weigh the risks and benefits of using this antibiotic over other comparable medications. In response to this study, a team from Denmark used their country's

national registries[4] to analyze the risk of cardiovascular death in individuals with no antibiotic use, with azithromycin use, and with penicillin use. *See* Henrik Svanstrom et al., *Use of Azithromycin and Death from Cardiovascular Causes*, New England Journal of Medicine 368 (May 2, 2013). They found no such risk. Access to a comprehensive dataset, akin to the APCD data, was helpful; as the researchers noted, "[g]iven the large, nationally representative study population, the results are likely to be widely generalizable to young and middle-aged adult populations" who are common users of these antibiotics. *Id.* The Danish researchers distinguished their results from the Tennessee study by noting that the risks associated with this common antibiotic may be limited to high-risk populations, *id.*, which would reflect the poorer health of the Medicaid population as compared to the general population. *See infra* pp. 20-21.

Research based on APCD data has also identified important discrepancies in American health services. In a 2014 study, researchers from Dartmouth College used the APCDs available in New England, including the Vermont APCD, to find that Medicaid insured children receive psychotropic prescriptions, including anti-depressants and anti-psychotics, at higher rates than commercially insured children. Shelsey J.

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[4] The Danish registries are not strictly an APCD in that Denmark has only one payer – the Danish Government – but function as one in that they collect all health care claims for the Danish population.

Weinstein, *Small Geographic Area Variations in Prescription Drug Use*, 132 Pediatrics 3 (Sept. 2014). Overall, prescription use among Medicaid-enrolled children was sixty-two percent higher than use among the commercially insured. *Id.* Additionally, there was significant variation in the rates of these prescriptions between regional health service areas. *Id.* The findings of this study are important in considering the quality of health care received by Medicaid insured children, which may prompt changes in Medicaid coverage and health care delivery policies. As the authors of this study note, "[t]hese findings should prompt discussion about the definitions and determinants of pediatric prescribing quality." *Id.* Without access to the New England APCDs, however, the research team would have found it very difficult to gather enough consistent claims data from the commercial insurance market to make valid comparisons between Medicaid insured children and commercially insured children. Similarly, it would have been difficult for them to gather enough data to make comparisons between health service areas.

APCDs can also be used to actively monitor and improve health services. A research team based in Boston used data from Maine's APCD to develop drug claims models to predict prescription opioid abuse. Alan G. White et al., *Analytic Models to Identify Patients at Risk for Prescription Opioid Abuse*, 15 The American Journal of Managed Care 12 (Dec. 2009). The team concluded that men age eighteen to thirty-four who either filled opioid prescriptions at multiple

pharmacies or refilled their opioid prescriptions early were significantly more likely to develop prescription opioid abuse issues. *Id.* The researchers explicitly noted the value of comprehensive claims data to this work, arguing that the "study demonstrates the feasibility of developing models derived from claims data variables to identify specific characteristics associated with elevated risk for prescription opioid abuse." *Id.* at 900-01. White et al. then noted that once researchers further developed these models using claims data, prescription drug monitoring programs could use these models to screen patients receiving opioid prescriptions or notify providers if patients met certain key risk factors, such as pharmacy shopping and early refills. *Id.* at 901. In fact, several state prescription drug monitoring programs have indicated an interest in using claims data as a clinical tool to help combat the opioid abuse epidemic. *Id.* Using claims data from individual insurers, or from Medicaid and Medicare only, would not have been as comprehensive and would have therefore limited the usefulness of the model they would have been able to develop.

2. APCDs Support Policy Analyses and Studies that Address Issues that Other Study Designs Cannot Address

Many laypeople conceive of medical research as the classic interventional experiments in which investigators apply a treatment to patients and perhaps contrast this group's outcome with a control group.

However, there is a significant body of health services knowledge that is best obtained from observational, population-based studies that reflect a full data set. This is particularly the case when a data system is designed to support planning and regulatory decision making affecting the performance of local and regional health care markets within the States.

The value of APCDs for this purpose was illustrated in the early 1970s by a team of researchers from the University of Vermont and other academic institutions. Using an early version of Vermont's APCD, the analysis uncovered heretofore unrecognized extensive variation among local hospital service areas in use of medical care. This included per capita medical spending, resource allocation (*e.g.*, physicians, hospital and nursing home beds), and utilization rates for elective surgery, medical hospitalizations, and physician visits. However, little or no variation was found in illness, economic status or outcomes of care. Moreover, the variation in spending and hospital bed supply could be traced in part to errors in regulatory decision making that could have been avoided if APCD data had been used. John Wennberg et al., *Small Area Analysis and the Challenge of Practice Variation*, 5 (Aug. 2015).

Starting in the 1990s, this group began the Dartmouth Atlas Project, which extended the practice variation analysis to the entire United States Medicare population. *The Dartmouth Atlas of Health Care*, available at http://www.dartmouthatlas.org/. Using the Dartmouth Atlas Project, researchers have been

able to identify when practice variation reflects a failure to deliver appropriate care, a divergence between physician opinion and the desires of informed patients, and an overuse of unwarranted services. Wennberg at 5-6. However, before the advent of APCDs the range of possible analyses this team could undertake was limited, restricted to single-payer or to exclusively hospital-based care using hospital registries.

The Dartmouth Atlas Project illustrates that unwarranted variation is a ubiquitous phenomenon, affecting all States. Uncovering this variation depends on population-based data. It is impossible to identify practice variation trends using experimental data or by using non-comprehensive claims data. Regional health care decision making cannot be studied in a laboratory because of the many "real world" pressures and factors that affect and influence these decisions. APCDs are thus essential for uncovering unwarranted practice variation and helping the States achieve a central objective of health care public policy by improving the effectiveness of health care and the efficiency of use of scarce and expensive hospital resources. *Id.* at 25.

B. Relying on Claims from Individual Insurers Results in Suboptimal Research.

Data from a single type of payer may only represent a fragmented portion of the American health care system. For example, Medicaid represents a

poorer, sicker population than the norm, Medicare represents an older population, and fully insured plans represent only a fraction of the commercially insured. Therefore, APCDs are one of the only data sources to provide researchers health care claims from the entire population in a State. The size of APCDs also provides datasets large enough to allow researchers to power certain important observational analyses that may not be available to more limited, payer-specific databases. Such observational analyses are one essential form of quantitative health services research.

1. Self-Funded Insurance Plans Serve a Different Population than Other Health Insurance Programs.

A database that included only claims from government payer programs, or even one that included claims from government payer programs and fully insured plans, would not be complete and therefore unable to approximate the health status of the American population as a whole. The population enrolled in self-funded insurance plans is a significant portion of health care users in this country and tends to be significantly younger and healthier than other populations.

As of 2014, fifteen percent of employees who obtained health insurance through their employers in small firms (3-199 workers) were enrolled in self-funded insurance plans. Gary Claxton et al.,

"Employer Health Benefits: 2014 Annual Survey," *Kaiser Family Foundation and Health Research & Education Trust*, 6 (Sept. 10, 2014), available at http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report. Eighty-one percent of employees at larger firms were enrolled in plans that were either partially or completely self-funded. *Id.* The larger the employer the more likely its employees are to be enrolled in a self-funded insurance plan. *Id.* at 174. Overall, sixty-one percent of employees who receive insurance through their employers are covered by a self-funded insurance plan. *Id.*

Removing a significant percentage of privately-insured individuals from health care databases significantly skews the remaining data to represent a sicker population. This is because, even controlling for income, Medicaid enrollees are much more likely to be significantly sicker and more disabled than their privately-insured counterparts. For example, among Medicaid enrollees at one hundred percent or less of the federal poverty level, thirty-eight percent were in fair or poor health, twenty-six percent reported physical or mental chronic conditions, and thirty-six percent were unable to work or could only pursue limited work due to their health. Kaiser Family Foundation, "Medicaid Enrollees are Sicker and More Disabled than the Privately-Insured" (Mar. 14, 2013), available at http://kff.org/medicaid/slide/medicaid-enrollees-are-sicker-and-more-disabled-than-the-privately-insured/. By contrast, among commercially insured individuals at one hundred percent or less of the

federal poverty level, only twelve percent were in fair or poor health, thirteen percent reported physical or mental chronic conditions and only six percent were unable to work or could only pursue limited work due to their health. *Id.* Similarly, because Medicare mostly covers elderly patients, its population skews much older than the commercially insured.

Because of the difference in the underlying populations, conclusions generated from Medicare- or Medicaid-only databases may not be generalizable to the broader health care system. For example, the Dartmouth Atlas Project was able to discover a number of low cost yet high quality health care organizations to provide benchmarks for efficient use of supply-sensitive care. These benchmarks can be used to save thirty percent of Medicare spending in managing patients with chronic illnesses. Wennberg at 25. However, because the Dartmouth Atlas cannot draw upon national private insurance claims data – due to a lack of APCDs in every State – it is limited to Medicare data. Because the Dartmouth Atlas is limited to Medicare data, it is difficult to use this resource to generate national benchmarks for private insurance.

Additionally, APCDs allow researchers to perform similar benchmarking for the privately insured population in States with these databases. Health insurers and self-funded insurance plans have data on their enrollees but this data only shows a fraction of the health insurance market in their area. With just the information on their enrollees, insurers do not

have a large enough sample size to perform certain necessary statistical analyses. Additionally, their enrollees may form a skewed population compared to the rest of the commercially insured population. This means any benchmarks developed based on fragmented data sets could be underpowered statistically and not reflect correct recommendations about best clinical care. In theory, insurers could cooperate to form joint databases but, in reality, competitors are unlikely to work together closely enough to create these types of databases. Indeed, researchers studying twelve health care communities across the United States concluded that "[w]hat is palpable . . . is the recognition that private market forces are limited in their ability to achieve social objectives in health care services. . . ." Len M. Nichols et al., *Are Market Forces Strong Enough to Deliver Efficient Health Care Systems?* 23 Health Affairs, 8-21, 21 (2004). Thus, State APCDs significantly facilitate researchers' ability to generate rigorous benchmarks for the commercially insured.

With sixty-one percent of the healthier commercially insured population potentially removed, APCDs will no longer provide an accurate portrait of the health of the general State population or of the enrollees of self-funded insurance plans. Researchers would be able to study health services as they relate to Medicaid and Medicare enrollees. However, they would be more limited in their ability to study the commercially insured because they would only receive fragmented datasets. This would impact their ability

to generate benchmarks, clinical care recommendations, and cost trends analyses regarding this population.

Moreover, they would not be able to generate these recommendations regarding the general population. APCDs are large enough to provide an accurate portrait of the health status of a population. It is important to get a sense of the general population's health status for key public health interventions such as herd immunity resulting from vaccination campaigns, as well as the population health of the American public. Population health can be defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group," and includes health outcomes, patterns of health determinants, and policies and interventions that link the two. David Kindig and Greg Stoddart, *What is Population Health?* 93 American Journal of Public Health 380-83, 380 (2003). Population health is a discipline that encourages providers to address upstream factors such as health promotion and care coordination in addition to direct clinical services and encourages stakeholders to improve health care delivery systems to improve health outcomes in their communities. The macro view of population health also dovetails and supports trends in health care spending to create global payment systems in both government and private payer fields, such as accountable care organizations and capitated payments. Michael A. Stoto, *Population Health in the Affordable Care Act Era*, Academy Health (Feb. 21, 2013). Population

health lastly helps inform health policy across all levels.

Thus, without APCDs it would be difficult for researchers to gain a clear sense of the overall trends in the general population and to generate best care recommendations for the commercially insured. While insurers are capable of coordinating data across the system to create private APCDs, they are unlikely to do so. Thus, State-mandated APCDs represent the best method for researchers to gain access to critical information about the commercially insured system as well as about the general American population.

2. Only APCDs Are Large Enough to Support Certain Statistical Analyses.

APCDs are some of the few databases that are large enough to provide data in sufficient amounts to power certain and necessary statistical analysis to understand our complex health system. Claims data provides information that other studies are incapable of capturing. As a research team from Harvard recently noted, "[s]haring electronic medical records and other secondary health care data sets facilitates observational studies by enabling rapid capture of a greater number of persons with exposures and outcomes of interest as well as by supplying a broader spectrum of study variables than would otherwise be possible if these resources were not shared." Ameet Sarpatwari et al., *Ensuring Patient Privacy in Data Sharing for Postapproval Research*, 371 New England

Journal of Medicine 1644-49, 1644 (Oct. 23, 2014). Sharing health care data "improve[s] statistical power, permit[s] more rigorous adjustment for confounding, and enable[s] more detailed subgroup analyses to better understand treatment-effect heterogeneity." *Id.* Claims data allow researchers to study treatments once they are approved by regulatory bodies such as the Food and Drug Administration as well as to study health services phenomena that are not suited to intervention studies and randomized controlled trials.

Frequentist statistics[5] form the bedrock of quantitative health services research and offer guidance on what inferences can be made from sample data such as claims data. Specifically, health services researchers use frequentist statistics to evaluate whether the difference in an observed outcome between two samples can be said to reflect a non-random difference between the populations the samples represent. By convention, a 'p-value' of less than 0.05 is often required for researchers to conclude that the differences between the studied sample populations are statistically significant and hence worth reporting. A p-value is dependent upon the size of the samples, the

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[5] Frequentist statisticians define probability as the long-run frequency of a certain measurement or observation. The more data collected, the closer a frequentist statistician can come to the "truth" of the matter. *See* Maarten H.P. Ambaum, *Frequentist vs Bayesian Statistics – a Non-Statistician's View*, Department of Meteorology, University of Reading (July 2012), available at http://www.met.reading.ac.uk/~sws97mha/Publications/Bayesvsfreq.pdf.

frequency of the outcome, and the magnitude of the difference in outcome between the samples; the larger the samples, the more frequent the outcome, and the greater the difference in outcome between the samples, the more likely a health services researcher can trust what was observed.

Statistical power refers to the ability, using frequentist statistics, to detect a non-random difference in outcome between populations from sample data with a specified level of certainty. To detect rare adverse events a very large sample is needed. For example, a Swedish team was able to identify a correlation between use of natalizumab, a monoclonal antibody used to treat Crohn's disease and multiple sclerosis, and progressive multifocal leukoencephalopathy (PML), a serious and usually fatal viral infection resulting in inflammation of the brain. Gary Bloomgren et al., *Risk of Natalizumab-Associated Progressive Multifocal Leukoencephalopathy*, 366 New England Journal of Medicine 1870-80 (May 2012). This study was important because natalizumab reduces the progression of disability in patients affected by multiple sclerosis by forty-two to fifty-four percent. *Id.* at 1871. Unfortunately, because of the risk of PML, this medication had been for a period of time voluntarily withdrawn by its manufacturer. *Id.* Because PML is a rare event, the Swedish team was only able to study this correlation by drawing upon comprehensive health care claims data from sources analogous to an APCD. Claims derived from a single

payer in the United States would not have generated a sufficiently large sample of this rare occurrence.

To detect treatment effect heterogeneity, *i.e.*, how individuals respond to a particular treatment, intervention or stimulation, often a very large and diverse sample is needed. APCDs are well-suited for this statistical purpose because their population of patients are both large and diverse; they include insurance claims from Medicare (older, sicker patients), Medicaid (younger, poorer, and sicker patients), and private insurance plans. As discussed above, *supra* at pp. 20-22, it is very challenging to replicate the mix of claims data APCDs collect in a State through individual insurer databases, government payer only databases, or databases that exclude self-funded insurance plans.

III. Upholding the Judgment Below Would Undermine The Nation's Ability To Address Health Care Cost Trends and Improve Health Care Outcomes.

APCDs are a crucial source of data for researchers studying health services. These databases permit researchers to evaluate and refine standards of care for general populations, generate recommendations for the commercially insured population, understand cost spending trends in health care, and study rare occurrences.

The important value of these data to researchers only underscores the gulf between the financial data

ERISA requires employee benefit plans to report and the health care claims data APCDs gather. Because ERISA only governs financial reporting, it should not preempt the Vermont statute requiring insurers to report health care claims data to the Vermont APCD.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

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Case No. 14-181

In the Supreme Court of the United States

ALFRED J. GOBEILLE, in his official capacity as Chair of the Vermont Green Mountain Care Board,

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

BRIEF OF *AMICI CURIAE* THE NATIONAL ASSOCIATION OF HEALTH DATA ORGANIZATIONS (NAHDO), ET AL. IN SUPPORT OF PETITIONER

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INTEREST OF THE *AMICI CURIAE*

The National Association of Health Data Organizations ("NAHDO") is joined by the All-Payer Claims Database ("APCD") Council, the Joint Public Health Informatics Taskforce ("JPHIT"), the Center for Improving Value in Health Care ("CIVHC"), and the Wisconsin Health Information Organization ("WHIO") as *amici* in support of the Petitioner.[1]

Founded in 1986, NAHDO is a national nonprofit membership and educational association, with members drawn from public and private sector health data organizations, including state and federal agencies. NAHDO is dedicated to improving health care data collection and use.

The APCD Council is a learning collaborative that fosters information sharing and best practices among those states which have developed or are seeking to develop all-payer claims databases.

JPHIT is a coalition of nine national public health associations, including the Association of State and Territorial Health Officials ("ASTHO") and the National Association of County & City Health Officials ("NACCHO"), which helps public health agencies build modern information systems across a spectrum of public health programs.

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[1] Pursuant to Supreme Court Rule 37.6, *amici* affirm that no counsel for a party authored this brief in whole or in part and that no person other than *amici* and their counsel made a monetary contribution to its preparation or submission. Pursuant to Supreme Court Rule 37.3, the parties have consented to the filing of amicus briefs and their letters of consent are on file with the Court.

CIVHC is a non-profit, non-partisan organization that helps Colorado drive, deliver, and buy value in health care. CIVHC is also the state-designated administrator for Colorado's all-payer claims database.

WHIO is an independent non-profit organization dedicated to improving the quality, affordability, safety, and efficiency of health care in Wisconsin, and manages a successful voluntary all-payer claims database.

Together, these organizations are deeply concerned about the data gaps and inevitable negative impact to health care reform that results from the absence of employer-sponsored self-funded health plans' data, especially in otherwise comprehensive statewide databases like Vermont's all-payer claims database. They consider this data especially critical since it represents the health care experiences of a large and growing set of working Americans in the prime of their lives, and their families.

SUMMARY OF ARGUMENT

The Second Circuit misapprehended the fundamental nature of all-payer claims database ("APCD") data submissions when it presumed that Vermont's are "burdensome, time-consuming, and risky" and thus pre-empted under the Employee Retirement Income Security Act of 1974 ("ERISA"). *See* Pet. App. 25. The majority, like Liberty Mutual, failed to explain "exactly how" this "obvious burden" manifests. In fact, they could not, because despite the dearth of discussion below, even a cursory understanding of how claims processing and APCD data submissions work dispels the fallacy.

Under this Court's established law, states may not enact statutes that contradict ERISA's core objective "to avoid a multiplicity of regulation[s] in order to permit the nationally uniform administration of employee benefit plans." *N.Y. State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 657 (1995) ("*Travelers*"). However, Vermont's APCD data submissions law does not concern, much less contradict, this core objective. No new or unique record-keeping is required. Moreover, Vermont's claims and eligibility data submissions are typical of those called for by other existing state APCDs and health data aggregation programs, including private, voluntary efforts.

Vermont's statute requires only the extraction, formatting, and submission of claims and eligibility data after it has already been collected, processed, and retained by organizations like Liberty Mutual's third-party administrator, Blue Cross Blue Shield of Massachusetts, in the routine course of business. The statute has no impermissible connection with employer-sponsored self-funded health plans, and thus is not subject to ERISA pre-emption.

Contrary to Liberty Mutual's position that APCD data submissions are overly burdensome and inappropriate, the long-standing consensus position of employers and business groups is that access to independent sources of claims and eligibility data is critical for health care reform. Simply put, Liberty Mutual is out of step with the trend in federal, state, and private sector initiatives, all of which demand increased transparency and measurability in health care.

This case presents the Court with an opportunity to reaffirm its rejection of the overly expansive view of ERISA pre-emption adopted by the Second Circuit, particularly where it thwarts Vermont's eminently reasonable efforts to improve health and health care for its citizens—an area traditionally regulated by the States. The Second Circuit decision should be reversed.

ARGUMENT

I. ERISA's Core Objective Of National Uniformity Is Not Contradicted By Vermont's Mandate To Submit Claims And Eligibility Data.

State law may not contradict ERISA's core objective "to avoid a multiplicity of regulation[s] in order to permit the nationally uniform administration of employee benefit plans." *Travelers*, 514 U.S. at 657. Vermont's APCD data submissions law does not concern, much less contradict, this core objective.

The Second Circuit misapprehended the fundamental nature of APCD data submissions when it presumed that they are "burdensome, time-consuming, and risky" and "obviously intolerable" as merely one of many "uncoordinated" regimes. Pet. App. 25. As the dissenting judge highlighted, the majority, like Liberty Mutual, failed to explain "exactly how" this "obvious burden" manifests. Pet. App. 39 (Straub, J., dissenting). In fact, they could not, because despite the dearth of discussion below, even a cursory understanding of how claims processing and APCD data submissions work dispels the fallacy.

Employer-sponsored self-funded health plans and their third-party administrators (all of whom we will refer to as "payers" or the "payer") are not required to collect or retain any new records but, instead, need only extract, format, and submit data they already collect and manage in the routine course of business. Moreover, Vermont's mandatory claims and eligibility data submissions are typical of those that payers make to other state APCDs and private, voluntary health data aggregation programs. Thus, Vermont's APCD data submissions law has no impermissible connection with employer-sponsored self-funded health plans.

A. No New Or Unique Record-Keeping Is Required.

The Second Circuit erred by holding that Vermont's APCD data submissions law is pre-empted, in part, because it requires certain "plan record-keeping." Pet. App. 23-25. The claims and eligibility data at issue are already collected and retained by payers in the routine course of business. Here, Blue Cross Blue Shield of Massachusetts fulfills that duty on behalf of Liberty Mutual and regularly supplies Vermont's APCD with claims and eligibility data from its systems for other employer-sponsored self-funded plans. *See* J.A. 205 ¶ 6 (explaining that for 2010 Blue Cross Blue Shield of Massachusetts reported on a total of 7,605 unique members, some 3,667 of whom were members of plans for which it acts as third-party administrator, and "[m]ost, if not all, of those plans are assumed to be ERISA plans").

The form and content requirements for data submissions to Vermont's APCD (and other similar

data aggregation programs) follow a common set of industry-driven technical standards adopted by the U.S. Department of Health and Human Services ("HHS"), under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), to standardize electronic transactions between payers and health care providers. *Compare* 45 C.F.R. pts. 160, 162 (adopting industry standards, as detailed below, for standard electronic health care transactions), *with* Vt. Regulation H-2008-01 (Pet. App. 107-141), Apps. C2, D2, & E2 (mapping claims and eligibility data submission requirements to the same standards) ("Vt. Regulation H-2008-01, Apps."), *available at* http://www.dfr.vermont.gov/sites/default/files/REG-H-08-01.pdf. Therefore, contrary to the Second Circuit's holding, no new or unique record-keeping is required.

HIPAA and its implementing regulations ensure health insurance portability and simplify administration by driving standardization among health care providers and payers for key electronic transactions. *See* Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Pub. L. No. 104–191, 110 Stat. 1936; 45 C.F.R. §§ 162.923, 162.925 (mandating adherence to transaction standards for HIPAA covered entities, including health plans and health care providers who interact electronically). These "transactions" span financial and administrative activities, including:

- **Health care claims or equivalent encounter information.**
- **Health care payment and remittance advice.**
- Coordination of benefits.

- Health care claim status.
- Enrollment and disenrollment in a health plan.
- **Eligibility for a health plan.**
- Health plan premium payments.
- Referral certification and authorization.
- First report of injury.
- Health claims attachments.
- Health care electronic funds transfers (EFT) and remittance advice.
- Other transactions that the [HHS] Secretary may prescribe by regulation.

45 C.F.R. § 160.103 (defining "transaction") (emphasis added). Each transaction standard prescribes in detail the data elements and protocol for exchanging the information.

Claims data generally follow a three-step path from health care provider to payer to APCD. First, seeking payment for a patient encounter or other service, a health care provider sends an electronic transaction to the applicable payer (whether public, like Medicare or Medicaid, or private, such as a commercial insurer or an employer-sponsored self-funded plan or its third-party administrator).

This claims transaction must adhere to HIPAA's specifications which, in turn, adopt industry-driven consensus standards, according to the claim type.[2]

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[2] As is true for any health plan-third-party administrator contractual relationship, under its HIPAA-mandated Business Associate Addendum with Liberty Mutual, Blue Cross Blue Shield of Massachusetts "shall be capable of transmitting electronic data for which transaction standards have been promulgated in

For most claims, including medical (both professional and institutional) and dental, HHS has endorsed standards developed by the Accredited Standards Committee X12 ("ASC X12" or "X12"), a broad committee with membership from across the health care and other industries.[3] 45 C.F.R. § 162.1102 (adopting ASC X12N 837 standards). For retail pharmacy drug claims, HHS has adopted standards from the National Council for Prescription Drug Programs ("NCPDP"), which focuses on specific information exchanges within the healthcare community.[4] *Id.* (adopting NCPDP standards). Both X12 and NCPDP are American National Standards Institute ("ANSI") accredited standards developers.

Next, the payer processes the claim. The payer provides information back to the provider and, if appropriate, makes payment, again following HIPAA-specified transaction standards. 45 C.F.R. § 162.1602 (adopting ASC X12N 835 standards for health claim payment/advice and other standards for certain electronic funds transfers). The payer retains claims data in its own record-keeping system. Here, Liberty Mutual's third-party administrator agrees to retain

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compliance with the HIPAA Electronic Transactions Rule, 45 CFR Parts 160 and 162." J.A. 66.

[3] A complete listing of ASC X12 members is available at http://www.x12.org/x12org/mbrship/mbr_list.cfm (last visited Sept. 3, 2015).

[4] A listing of current NCPDP Work Group Co-Chairs, including representatives of payers, such as pharmacy benefits management organizations ("PBMs"), is available at https://www.ncpdp.org/NCPDP/media/pdf/2015_2016_Co-Chairs.pdf. PBMs play a role similar to third-party administrators for processing prescription drug claims and also provide APCD data submissions.

"auditable documentation" for two years (although older claims may be disputed for an additional fee, implying that such data is available). *See* J.A. 89.

Finally, the payer extracts the existing claims data from its system, based on appropriate criteria, and formats it for submission to others to whom it is obliged (or volunteers) to submit data, including, where applicable, one or more APCDs. These claims data extraction and formatting activities are performed on a routine basis. For example, under the *Administrative Services Agreement*, Liberty Mutual's third-party administrator is required to provide it with "a paper copy of a monthly claims listing," or at Liberty Mutual's election, the data will be provided in other forms, including electronic format. J.A. 87-88. Data submissions to Vermont's APCD—like those Liberty Mutual's third-party administrator makes for other employer-sponsored self-funded health plans—occur monthly, quarterly, or annually, according to the total number of individuals for whom it pays claims. Pet. App. 128.

Eligibility data denotes individuals who are entitled to receive care under a health plan, including member demographic information and plan type. The payer's business necessarily dictates that it collect and retain such data regarding its individual members or beneficiaries. As with claims, a health care provider sends an electronic transaction to the payer to inquire as to eligibility and receives a payer response, based on data retained in the payer's system. Again, HIPAA regulations adopt industry-driven consensus standards for the information exchange. 45 C.F.R. § 162.1202 (adopting ASC X12N 270/271 standards for most inquiries and NCPDP

standards for retail pharmacy). For APCD and other data submissions purposes, eligibility data is similarly extracted from the payer's system and formatted accordingly.

By design, Vermont's APCD regulations closely parallel the HIPAA transaction standards for claims and eligibility data. Detailed element by element mappings—found in a series of appendices to the regulation aptly titled "Member Eligibility File Mapping to National Standards," "Medical Claims File Mapping to National Standards," and "Pharmacy Claims File Mapping to National Standards"—assist payers in extracting data and formatting it for submission. *See* Vt. Regulation H-2008-01, Apps. For instance, the "Principal Diagnosis" to be included in medical claims data submissions maps to the same field in the HIPAA-adopted ASC X12N 837 standard. *Id.* at App. D2, 47 (Data Element MC041, Principal Diagnosis, HIPAA reference 837/2300/HI/BK/01-2).

In the scant discussion of burden below, Liberty Mutual implied that some special imposition accompanies Vermont's requirement that APCD claims data submissions "includ[e] such detail as the admission hour. . . expressed in military time HHMM in the case of all inpatient claims." Reply Brief for Pl.-Appellant Liberty Mutual at 17, *Liberty Mut. Ins. Co.* v. *Donegan*, No. 12-4881 (2d Cir. July 17, 2013), ECF No. 88 (internal citations omitted). Yet, that admission time data is no more than the same information for the same field mandated by the ASC X12N 837 standard, adopted in the HIPAA regulations and routinely submitted by providers to payers, as shown in Vermont's mapping. Vt. Regulation H-2008-01, Apps. at App. D2 (Data Element MC019,

Admission Hour, HIPAA Reference 837/2300/DTP/435/03).

B. The Claims And Eligibility Data Submissions Mandated By Vermont Are Typical Of Other State APCDs And Health Data Aggregation Programs.

Vermont's mandatory statewide data aggregation through its APCD offers an effective and efficient approach to ensuring comprehensive representation which, in turn, enables health care cost and utilization studies important to Vermont. Today, the Vermont APCD includes claims data "for 90 percent of commercially insured [fully-insured and employer-sponsored self-funded] Vermonters and 100 percent of Medicaid and Medicare enrollees." Green Mountain Care Board, *Vt. Health Care Uniform Reporting and Evaluation System (VHCURES)*, http://gmcboard.vermont.gov/vhcures (last visited Sept. 3, 2015).

Because the claims and eligibility data submissions required by Vermont closely parallel the HIPAA transaction standards (which in turn adopt X12 and NCPDP consensus standards), the data Vermont collects is typical of other state APCDs and health data aggregation programs. Using a simple but lengthy chart, the United States Health Information Knowledgebase ("USHIK"), maintained by HHS's Agency for Healthcare Research and Quality ("AHRQ"), demonstrates this extensive overlap in APCD data elements and X12 standards across several statewide APCDs, including those of Vermont, Maine, Massachusetts, Minnesota, New Hampshire, and Tennessee. *See* AHRQ, USHIK, APCD to ASC

X12 Relationship Mapping, https://ushik.ahrq.gov/APCDGroupings?system=apcd&enableAsynchronousLoading=true (last visited Sept. 3, 2015).

While the data extraction, formatting, and submissions procedures they prescribe for payers vary somewhat, the similarity in claims and eligibility data collected by state APCDs, including Vermont, is further demonstrated by the references to the HIPAA-adopted X12 and NCPDP standards uniformly made in their data submissions guides.[5] This commonality in the claims and eligibility data aggregated by state APCDs also enables regional studies and resource sharing among states. For instance, such "harmonization" supported a recent multi-state study on variations in health services utilization across Maine, New Hampshire, and Vermont. *See* J.A. 219-20; *see generally* Karl Finison, Onpoint Health Data, *Tri-State Variation in Health Services*

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[5] States that mandate APCD submissions publish a data submissions guide or similar resource instructing payers on appropriate data extraction, formatting, and submission procedures. These guides also provide detailed references enabling payers to link APCD data elements to those in their own systems. *See, e.g.*, Ctr. for Improving Value in Health Care (CIVHC), *Colo. All-Payer Claims Database Data Submission Guide* 12-24, 27-50, 52-58 (Version 6) (March 2014), *available at* http://www.civhc.org/getmedia/c4071074-ecc4-457b-bd40-72fee47ee639/Data-Submission-Guide-V6-March-2014-FINAL_1.pdf.aspx/ (showing references to the X12 and NCPDP standards for claims and eligibility data elements); Access Health CT, *Conn. All Payers Claims Database Data Submission Guide*, Data Content Guides attached to Data Submission Guide 18-69 (Version 1.2 (with clarifications)) (Dec. 5, 2013) (same), *available at* http://www.ct.gov/hix/lib/hix/CT_DSG_-12132014_version_1.2_%28with_clarifications%29.pdf.

Utilization & Expenditures in Northern New England (June 2010), *available at* https://www.apcdcouncil.org/file/112/download?token=9T0EDRtz.

Extracting, formatting, and submitting claims data to APCDs and others is a routine, straightforward process for payers, which already have sophisticated claims processing systems and information technology capabilities. Even so, the APCD community and interested stakeholders regularly collaborate to further streamline the process. This additional standardization speeds up APCD data availability (which by its nature lags behind individuals' receipt of health care services) and facilitates multistate studies. For instance, during the summer of 2011, X12 and the APCD Council began an initiative to develop a "Uniform Medical Claims Payer Reporting Standard" through X12's insurance subcommittee and its working groups. Press Release, X12, *Development of a Uniform Medical Claims Payer Reporting Standard* (Aug. 15, 2011), *available at* http://store.x12.org/store/contact-us/8-news/165-development-of-a-uniform-medical-claims-payer-reporting-standard.

Just one year later, X12 approved publication of several "implementation guides" instructing states and others that aggregate claims data on "eas[ing] the burden for payers required to submit such data, increas[ing] the quality of the data, and reduc[ing] the implementation costs for the health care industry." Press Release, X12, *ASC X12 Announces Technical Reports for Post-Adjudicated Health Care Claims Data Reporting Available* (Aug. 13, 2012), *available at*

http://www.x12.org/x12org/docs/ACFCD5.pdf. More recently, the APCD Council published model legislation to guide states that may be considering APCD authorization. APCD Council et al., *Model All-Payer Claims Database (APCD) Legislation* (May 2015), *available at* http://www.apcdcouncil.org/publication/model-all-payer-claims-database-legislation.

These nationwide multi-stakeholder efforts to further standardize APCDs and their data extraction, formatting, and submissions procedures reflect the explicit intent expressed by some state legislatures. For example, Nebraska requires its Health Care Data Base Advisory Committee to "[i]nclude discussions regarding the standardization of the Nebraska Health Care Data Base with other states and regions and federal efforts concerning all-payer claims databases." Neb. Rev. Stat. § 71-9204(1)(g). And in Virginia, where APCD submissions are voluntary, the data "shall be developed in a format that allows comparison of information in the All-Payer Claims Database with other nationwide data programs and that allows employers to compare their employee health plans statewide and between and among regions of the Commonwealth and nationally." Va. Code Ann. § 32.1-276.7:1(E)(1).

Such legislatively-created advisory committees, and other governance structures ranging from boards to consultation requirements, exist in most APCD states and address a wide array of issues. Various business interests, including those of payers and employers, are represented and often specifically identified by state law. For instance, the Vermont Green Mountain Care Board enabling statute re-

quires that the Board "shall establish a consumer, patient, business, and health care professional advisory group to provide input and recommendations to the Board," and currently includes payer representation. Vt. Stat. Ann. tit. 18, § 9374(e)(1); State of Vt., Green Mountain Care Board, *GMCB Advisory Committee Members*, http://gmcboard.vermont.gov/advisory_groups/members (last visited Sept. 3, 2015). The Maine Health Data Organization's board must include two representatives of "third-party payors," selected from a group that includes insurers and third-party administrators. Me. Rev. Stat. tit. 22, §§ 8702, 8703.

In another example, Massachusetts's Center for Health Information and Analysis is directed to "consult with . . . affected payers, as applicable, to ensure that the reporting requirements imposed under the [APCD] regulations are not duplicative or excessive" prior to promulgating regulations. Mass. Gen. Laws ch. 12C, § 5. Most recently, Arkansas's law establishes a "Healthcare Transparency Initiative Board" that must include "[t]wo representatives from the health insurance industry" and a self-insured employer representative. S. 956, 90th Gen. Assembly, Regular Sess., at 6 (Ark. 2015) (to be codified at Ark. Code Ann. § 23-61-905) ("*Ark. APCD Statute*"), *available at* http://www.arkleg.state.ar.us/assembly/2015/2015R/Acts/Act1233.pdf.

Finally, payers routinely engage in private, voluntary health data aggregation initiatives that necessarily rely on claims data submissions. California's multi-payer claims database, part of the California Healthcare Performance Information System

("CHPI"), accepts claims data from "the state's three largest health plans": Anthem Blue Cross, Blue Shield of California, and UnitedHealthcare. CHPI, *Multi-Payer Claims Database (MPCD)*, http://www.chpis.org/programs/mpcd.aspx (last visited Sept. 3, 2015). This database includes both insured and self-funded claims, along with Medicare data, representing some 12 million lives. *Id.*

These and other private, voluntary efforts (*see infra* Section III.C) demonstrate the ease with which payers can extract, format, and submit claims and eligibility data for data aggregation purposes. But while the sheer data volume may sound impressive, such efforts inevitably result in only partial views. State-mandated APCDs that aggregate fully-insured and employer-sponsored self-funded claims, as well as Medicaid and Medicare data (like Vermont's and others'), ensure the broadest representation and are uniquely positioned to offer data analyses and reports attuned to local needs. *See* APCD Council, *Interactive State Report Map*, *available at* http://www.apcdcouncil.org/state/map (last visited Sept. 3, 2015) (depicting current and planned data coverage for statewide APCDs). Employer-sponsored self-funded claims data is particularly critical to state APCDs because it represents a growing segment of healthy working adults in the prime of their lives, and their families. *See* Kaiser Family Found. et al., *Employer Health Benefits, 2014 Annual Survey* 176 ("*Kaiser Family Report*"), *available at* http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report (explaining growth in percentage of insured workers covered by self-funded plans from 44% to 61% since 1999).

C. Vermont's APCD Data Submissions Law Has No Impermissible Connection With Employer-Sponsored Self-Funded Health Plans.

Vermont's APCD data submissions law does not "create[] [an] impediment to an employer's adoption of a uniform benefit administration scheme," but instead seeks "to address uniquely local social and economic problems." *See Fort Halifax Packing Co., Inc.* v. *Coyne*, 482 U.S. 1, 14, 19 (1987). The Vermont statute requires only the extraction, formatting, and submission of claims and eligibility data after it has already been collected, processed, and retained by the payer. Thus, it also does not impermissibly "affect[] an ERISA plan's 'system for processing claims and paying benefits.'" *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 150 (2001) (quoting *Fort Halifax Packing Co.*, 482 U.S. at 10).

This Court has concluded that state statutes that have an "indirect economic influence" on ERISA plans do not "relate to" them as long as the statute does not "force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers." *Travelers*, 514 U.S. at 668. For example, in *Travelers*, this Court held that a state statute requiring hospitals to collect surcharges from patients covered by commercial insurers was not pre-empted by ERISA because it only had an "indirect economic influence" on the cost of insurance policies. *Id.* Similarly, Vermont's statute does not require an ERISA plan to collect new or unique data or to endure any undue financial burdens. As the Second Circuit dissent suggests, the cost of submitting

claims and eligibility data in the required format is minimal and, at most, will have a minor and "indirect economic influence" on ERISA plans, in large part because employer-sponsored self-funded plans (or as in Liberty Mutual's case, their third-party administrators) "already have [such claims data] in their possession." Pet. App. 39-44.

Some state statutes have been held to have a "connection to" ERISA plans if they interfere with "nationally uniform plan administration." For instance, this Court held that ERISA pre-empted a Washington statute governing the payment of benefits—"a central matter of plan administration"—to plan beneficiaries, *Egelhoff*, 532 U.S. at 147-48, and a Pennsylvania anti-subrogation law that "require[d] plans to calculate benefit levels in Pennsylvania based on expected liability conditions that differ[ed] from those in States that ha[d] not enacted similar . . . legislation." *FMC Corp.* v. *Holliday*, 498 U.S. 52, 60 (1990).

But unlike the state statutes in *FMC Corporation* and *Egelhoff*, the Vermont APCD data submissions law does not require plan administrators to choose between complying with state law or the ERISA plan itself, nor does it interfere with "nationally uniform plan administration" by requiring administrators to offer substantively different ERISA plans in different states. *Compare Fort Halifax Packing Co., Inc.*, 482 U.S. at 14 (concluding that the state's statute "create[d] no impediment to an employer's adoption of a uniform benefit administration scheme" because the law did not "put the employer to the choice of either (1) integrating a state-mandated ongoing benefit plan with an existing plan or (2) establishing a

separate plan to process and pay benefits under the plan required by the State."), *with Egelhoff*, 532 U.S. 141 at 147 (statute pre-empted because it bound "plan administrators to a particular choice of rules for determining beneficiary status. The administrators must pay benefits to the beneficiaries chosen by state law, rather than to those identified in the plan documents.").

Vermont's statute merely calls for claims and eligibility data aggregation, after it has already been collected and retained by payers, to address "uniquely local social and economic problems," such as rising health care costs and the accompanying need for data transparency. This Court's precedent weighs against "disabling it from attempting to address" these issues since the statute "creates no prospect of conflict with a federal statute." *See Fort Halifax Packing Co., Inc.*, 482 U.S. at 19. Moreover, Vermont's APCD data submissions law does not "frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide." *FMC Corp.*, 498 U.S. at 60.

Finally, below, Liberty Mutual implied (and the Second Circuit apparently agreed) that its ERISA obligations may be thwarted because Vermont's APCD data submissions law requires it to compromise individual privacy. Pet. App. 25, 27-29, 29 n.13. To the contrary, Vermont mandates that payers apply a one-way, non-reversible hash algorithm[6] to re-

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[6] "Hashing" is sometimes referred to as a form of "encryption," but the notable difference is that unlike most encryption schemes that allow for data decryption (i.e., recovery), with an appropriate "key," hashing is a one-way, non-reversible process that replaces the otherwise sensitive data with gibberish.

move data elements that directly identify an individual when formatting (and prior to making) their data submissions, using software that Vermont provides. J.A. 133. As further explained in Vermont's current data submission guide:

> [Vt.'s contractor]'s data collection system ensures that direct member identifiers remain secure — both at rest and in motion — through the use of a federally recommended hashing algorithm. This hashing is not performed by [Vt.'s contractor]; instead, it is performed locally by health plans [or their third-party administrators]. Using [Vt.'s contractor]'s system, all fields specified as "encrypted" in Vermont's Regulation H-2008-01 are hashed upon preparation for submission, remain solely within the health plan's platform, and are neither transmitted nor received by [Vt.'s contractor].

Onpoint Health Data, *Data Submission Guide for the Vt. Health Care Uniform Reporting & Evaluation System (VHCURES)* 13 *(Version 2.0)* (July 2015), available at http://www.onpointhealthdata.org/clients/vhcures/docs/onpoint_vhcures_dsg_v20.pdf. Stated differently, in contrast to the payers' systems, the data maintained by Vermont's APCD does not include the personally identifiable data so attractive to cyber-attackers, and the hashed information cannot be "decrypted" or otherwise recovered. At the same time, requiring payers to use the same hashing software supports important longitudinal studies that

span claims data submitted by different payers, provided that the underlying member data matches prior to its hashing.

II. The Long-Standing Consensus Position Of Employers And Business Groups Is That Access To Claims And Other Utilization Data Is Critical For Health Care Reform.

Contrary to Liberty Mutual's position that APCD data submissions are overly burdensome and inappropriate, employers and business groups have long advocated for and supported greater healthcare data transparency. In the late 1970s and early 1980s, "business health care coalitions," composed mainly of employer-purchasers, grew in response to rapidly escalating health care costs, and data initiatives played an important role. *See generally* Carol Cronin, *Business Coalitions on Health: Their Activities and Impact*, Joint Commission 20 J. Quality Improvement 376, 376-80 (1994).

Such concerns drove the creation of *amicus* the National Association of Health Data Organizations ("NAHDO") in 1986 by the Washington Business Group on Health and the Intergovernmental Health Policy Project at George Washington University in an effort to facilitate coordination among state-level health data agencies and promote public-private cooperation. *See* NAHDO, *About NAHDO*, https://www.nahdo.org/about (last visited Sept. 3, 2015).

These activities have greatly expanded in number and participation—no surprise since today employers provide health benefits for some 149 million non-

elderly Americans, with 61% covered by a plan that is at least partially self-funded. *Kaiser Family Report* at 56, 174.

"Health care performance indicator information is a **public good**, whereby all patients, purchasers, and providers should have access to a common set of performance information." Patrick Miller, *Why State All-Payer Claims Databases Matter to Employers*, 12 Pension & Benefits Daily 114 (June 14, 2012) ("*Why APCDs Matter*") (emphasis added) (quoting Ted von Glahn, senior director, Pacific Business Group on Health).[7]

From the perspective of the business community, APCDs provide an independent source of data, independence being a characteristic important for cultivating employee trust. Nat'l Bus. Coal. on Health,[8] Action Brief, *Price Transparency: Now More than Ever* (May 2012), *available at* https://www.nbch.org/nbch/files/ccLibraryFiles/Filename/000000002934/Final%20price%20transparency.pdf (emphasizing the use of independent data sources to foster employee trust and contrasting Or-

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[7] The Pacific Business Group on Health is one of the nation's most prominent employer-purchaser coalitions, based in no small part on the high profile of its corporate and public agency members. A complete membership list is available at http://www.pbgh.org/about/members (last visited Sept. 3, 2015).

[8] Founded in 1992, the National Business Coalition on Health ("NBCH") includes 52 business health coalitions nationwide that represent over 4,000 employers and some 35 million employees and their families. For more information about NBCH, *see* http://www.nbch.org/About-NBCH (last visited Sept. 3, 2015). A complete membership list is at http://www.nbch.org/NBCH-Coalition-Members (last visited Sept. 3, 2015).

egon's mandatory APCD—created by a neutral party which, in turn, was overseen by an "all-stakeholder" board—to information from health plans, employers, or the government that employees may perceive as biased). Because large, self-insured employers need representative information, "every state[] needs to implement an APCD." *Why APCDs Matter* at 118 (quoting Barbara Belovich, executive director, Health Action Council Ohio).

The value placed on APCDs by the business community is dramatically highlighted in a recent employer-supported 50-state price transparency report card—the only five states with non-failing grades have a statutorily-created APCD. Catalyst for Payment Reform, *Report Card on State Price Transparency Laws* 2 (July 2015), *available at* http://www.catalyzepaymentreform.org/images/documents/2015_Report_PriceTransLaws_06.pdf.[9]

Small business groups also support APCDs as a trusted resource for their employees. Reacting to Washington State's new mandatory-submissions APCD law, the Nat'l Federation of Independent Business ("NFIB") stated, "[small-business owners, employees, and their families] deserve access to meaningful cost and quality information to make informed health-care decisions. This APCD is the foundation for better information and lower costs. . . . Experience in other states has shown that without

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[9] Catalyst for Payment Reform's members include some of the nation's largest employers (*e.g.*, AT&T, FedEx, GE, Walmart), public employee and retiree organizations, and Medicaid agencies. A complete member list is available at http://www.catalyzepaymentreform.org/site-map/cpr-members (last visited Sept. 3, 2015).

a mandate, it is impossible to provide a comprehensive picture of the cost and quality of health care." NFIB, *News Release--Governor Could Finally Give Consumers an Effective All-Payer Claims Database* (Apr. 20, 2015), http://www.nfib.com/article/legislature-passes-health-care-transparency-bill-68901/ (commenting on Wash. E.S.S.B. 5084, enacted May 14, 2015, as Wash. Rev. Code ch. 246, § 2).

Business health care coalitions continue to press for APCD expansion. Despite large-scale voluntary efforts in California (*see* "CHPI," *supra* Section I.B), the Pacific Business Group on Health recently went on the record in support of legislation to create a new "California Health Care Cost and Quality Database" that includes, among other elements, mandatory claims data submissions. *See* S. 26, 2015-2016 Reg. Sess. (Ca. 2015) (introduced May 28, 2015), *available at* https://legiscan.com/CA/bill/SB26/2015; Pac. Bus. Grp. on Health Letter to Bill Sponsor Sen. Ed Hernandez (Apr. 17, 2015), *available at* http://www.pbgh.org/storage/documents/PBGH_SB26_SupportLetterwAmend.pdf (supporting S. 26 with the addition of amendments, "[i]nformation on how well care is provided and how much it costs is important to improving quality and addressing cost containment in California").

Broader health data transparency efforts, including Medicare claims data releases, as called for in the Patient Protection and Affordable Care Act ("Affordable Care Act") have also garnered support from high-profile business groups. *See* Pub. L. No. 111–148, § 10332, 124 Stat. 119, amended by the Health Care and Education Reconciliation Act of 2010, Pub.

L. No. 111–152, 124 Stat. 1029; *see infra* Section III.A. "The U.S. Chamber of Commerce and our member companies have long advocated in support of the release of medical claims data to facilitate performance reporting that would reflect provider quality and improve transparency while ensuring beneficiary privacy." Letter from Randel K. Johnson & Katie Mahoney for Dep't of Health & Human Servs, Ctrs. for Medicare & Medicaid Servs. ("CMS"), U.S. Chamber of Commerce, *Comment Letter Re: Proposed Rule Regarding the Availability of Medicare Data for Performance Measurement, RIN 0938-AQ17* (Aug. 8, 2011), *available at* http://www.regulations.gov/#!documentDetail;D=CMS-2011-0122-0079 (supporting "broader and richer uses" of Medicare claims data).[10]

Beyond their roles in advocacy and as data consumers, employers and business groups provide hands-on support and leadership for APCDs and other health data aggregation programs. As explained above, many states' APCD authorizing statutes call for advisory committees and other governance structures, populated, in part, by employers and business groups. *See supra* Section I.B; *see, e.g.*,

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[10] It seems incongruous that the U.S. Chamber of Commerce would advocate for greater release of public payer claims data to improve health data transparency, while below, as *amicus*, it argued that similar claims data releases by employer-sponsored self-funded plans and their third-party administrators to state APCDs would have a "deleterious impact" on employers and could even result in employers decreasing the health benefits they provide. Brief of *Amicus Curiae* Chamber of Commerce of the U.S.A. in Support of Reversal at 2, 6, 10-11, *Liberty Mut. Ins. Co.* v. *Donegan*, No. 12-4881 (2d Cir. Apr. 9, 2013), ECF No. 64.

Ark. APCD Statute (specifying Healthcare Transparency Initiative Board members must include representatives of self-insured and small employers); Colo. Rev. Stat. § 25.5-1-204 (APCD Advisory Committee must include representatives of both small and large employers). Board membership rolls for private health data aggregation programs—typically time-consuming volunteer activities for busy businesspeople—provide further evidence of the priority placed on fostering greater data transparency. *See, e.g.*, CHPI, *Board of Directors*, http://www.chpis.org/about/board.aspx (last visited Sept. 3, 2015); Maine Health Management Coalition, [11] *Committees and Workgroups*, http://www.mehmc.org/about-us/committees-workgroups/ (last visited Sept. 3, 2015) (describing its thirteen-member Board of Directors as including seven employers/plan sponsors).

That employers and business groups support the public good provided by APCDs and other health data programs comes as no surprise. They recognize that transparency produces better informed employer-purchasers and employee-consumers, while enabling data-driven cost containment, advocacy, and policymaking. In addition to public reporting and research studies, some creative businesses have sought to benefit even more directly by making their own APCD data release requests. For example, the Maine APCD has apparently accepted at least two data re-

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[11] The Maine Health Management Coalition has received multiple data releases from Maine's APCD. *See* Maine Health Data Organization, *Current Data Requests*, https://mhdo.maine.gov/datarequest.aspx (last visited Sept. 3, 2015).

lease requests in support of self-insured employer reinsurance activities. *See* Maine Health Data Organization, *Current Data Requests* 12-13, https://mhdo.maine.gov/datarequest.aspx (last visited Sept. 3, 2015) (explaining data requests by Integrated Benefit Solutions, LLC and the Human Capital Resource Group).

Individual employers, like Liberty Mutual, inevitably benefit from the increased transparency provided by APCDs and other health data aggregation programs. They should not be allowed to hide behind an overly expansive reading of ERISA pre-emption that this Court has previously rejected and free ride on others' data.

III. Liberty Mutual Is Out Of Step With The Trend In Federal, State, And Private Sector Initiatives Demanding Increased Transparency And Measurability In Health Care.

While the appropriate role of the federal government in reforming the individual and small group health insurance markets may continue to be debated for some time, federal and state policymakers, health care industry leaders, and policy experts have found common ground for more than a decade on the need to improve patient outcomes and reduce the rate of rising health care costs in the United States. In recognition of the need to realign economic incentives across the health care sector, Congress and the Administration have undertaken bipartisan efforts to reform Medicare's payment systems—a key driver of reforms in the nation's other public and private health care payment systems. The success of these

efforts depends in significant part on the availability of data from the broadest possible cross-section of the community to facilitate the measurement of cost, quality, and performance of our health care system.

The most commonly available and standardized data for such purposes are payers' claims and eligibility data. Such data plays a growing role in helping federal, state, and local governments, and private sector stakeholders, meet the challenges of improving "population health"[12] because of its capacity to provide a holistic view of health care consumers' interactions with various components of a community's health care system, including information about the demographics of consumers receiving care, care set-

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[12] As health reform efforts have taken hold in the United States, health policy experts have begun using the term "population health" to refer to "the health outcomes of a group of individuals, including the distribution of such outcomes within the group." David Kindig and Greg Stoddart, *What is Population Health?*, Am. J. Pub. Health, March 2003, at 380, *available at*, http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.93.3.380; *see also* David Kindig, *What Are We Talking About When We Talk About Population Health?*, Health Affairs Blog (April 6, 2015), http://healthaffairs.org/blog/2015/04/06/what-are-we-talking-about-when-we-talk-about-population-health/ (urging that "population health" be used to refer to geographic populations, and that terms such as "population health management" and "population medicine" describe "activities limited to clinical populations and a narrower set of health outcome determinants"); N.Y. State Dep't of Health, *Background and Context for Conducting Literature Review*, http://www.health.ny.gov/statistics/chac/usefulcha/background.htm (last visited Sept. 3, 2015) ("The population health perspective includes a focus on resource allocation and accountability, implying the need for measures of health outcomes and evidence linking interventions to those outcomes").

tings, types and patterns of care, and, given the reimbursement purpose for the data, the cost of care.

Providers have been submitting electronic claims data in a standardized format for over a decade in response to HIPAA and its implementing regulations governing "standard transactions." *See supra*, Section I.A. In contrast, the electronic storage and availability of detailed clinical data was not significantly advanced until the passage of the Health Information Technology for Economic and Clinical Health ("HITECH") Act, enacted under Title XIII of the American Recovery and Reinvestment Act of 2009 ("ARRA"), Pub. L. No. 111–5, 123 Stat. 115.[18]

Clinical data in electronic health records ("EHRs") can provide a more fulsome picture of a particular patient, help identify medical conditions, and facilitate analysis of the health status of a provider group's full patient population. However, while electronic health records hold great promise for broader population health management, particularly when effectively integrated with claims data, the availability of EHRs for such purposes remains limited. Unlike claims and eligibility data, the clinical data contained in electronic health records are not yet sufficiently standardized or shared across organizational, vendor, and geographic boundaries to permit population-wide analytics. Moreover, compared to long-studied claims data, as found in Vermont's and other APCDs, the level of clinical detail

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[18] Despite the broad wording found in Vt. Stat. Ann. tit. 18, § 9410, Vt. Regulation H-2008-01 (Pet. App. 107-141), at issue here, is focused on health plan (*i.e.*, payer) claims and eligibility data.

found in EHRs, including physician notes, may raise further privacy concerns.

A. The Affordable Care Act And The Medicare Access And CHIP Reauthorization Act Of 2015 Are Only The Most Recent Examples Of Bipartisan Federal Support For Greater Health Data Transparency.

In health care reform legislation enacted over the past fifteen years,[14] Congresses led by both parties have sought to leverage the purchasing power of Medicare to drive reform in the health care sector as a whole. Since passage of the Affordable Care Act, efforts have accelerated among public and private purchasers of health care, including employers, to become active purchasers of care at lower cost and higher value. The Secretary of HHS's announcement in January 2015 that Medicare would shift 50 per-

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[14] *See, e.g.*, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. No. 106–554, 114 Stat. 2763 (establishing one of the first Medicare pay-for-performance initiatives). Sections 646, 649, & 721 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108–173, 117 Stat. 2066 (creating programs promoting the use of health information technology and pay-for-performance models to improve the care of chronically ill Medicare beneficiaries); Section 5001(b) of the Deficit Reduction Act of 2005, Pub. L. No. 109–171, 120 Stat. 4, and Section 131(d) of the Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 110–275, 122 Stat. 2494 (authorizing hospital value-based purchasing programs). *See also* Exec. Order No. 13,335, 69 Fed. Reg. 24,059-61 (Apr. 27, 2004) (establishing the HHS Office of the National Coordinator for Health Information Technology under the Bush Administration).

cent of its provider payments into alternative payment arrangements such as accountable care organizations or bundled payments by 2018 was promptly followed by public commitments from representatives of health care payer, provider, and purchaser organizations (including the Pacific Business Group on Health) to have 75 percent of their respective businesses operating under value-based payment arrangements that focus on the "Triple Aim" of better health, better care, and lower costs by January 2020. Press Release, Health Care Transformation Task Force, *Major Health Care Players Unite to Accelerate Transformation of U.S. Health Care System* (Jan. 28, 2015), *available at* http://www.hcttf.org/releases/2015/1/28/major-health-care-players-unite-to-accelerate-transformation-of-us-health-care-system.

Four months later, a Republican-led Congress expanded Medicare data-sharing provisions in the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), Pub. L. No. 114–10, 129 Stat. 87, which President Obama signed into law on April 16, 2015. MACRA not only converts Medicare's payment structure for physicians to a pay-for-performance model, it also expands HHS's ability to share standardized extracts of Medicare Part A, B, and D claims data with qualified public and private entities for purposes of "assisting providers of services and suppliers in developing and participating in quality and patient care improvement activities, including developing new models of care." *Id* at § 105 (a)(2)(B).

Section 10332 of the Affordable Care Act had established the "Qualified Entity" program to allow the Secretary of HHS to provide Medicare claims data

under Parts A, B, and D to Qualified Entities for the evaluation of the performance of providers of services and suppliers—and requires recipients to publish their analyses. 42 U.S.C. § 1395kk(e). MACRA § 105(a) expands the program and, beginning July 1, 2016, allows certain Qualified Entities—including employers—to use Medicare claims data to conduct "private analyses" and provide or sell such data for private use.[15] MACRA leaves unchanged the expectation established in Affordable Care Act § 10332 that Qualified Entities will not rely solely on Medicare data to conduct performance measurements, but will include claims data from other sources. 42 U.S.C. § 1395kk(e)(4)(B)(iii); *see also* 42 C.F.R. §§ 401.703(h), 401.709(b)(2) (establishing a conditional approval process for applicants that do not have access to other claims data at the time of their application to become a "Qualified Entity").

Employers, as defined in ERISA § 3(5), are expressly eligible to receive Medicare claims data analyses for purposes of providing health insurance to their employees and retirees. MACRA §§ 105(a)(1)(B)(i) & (9)(A)(iii). Passage of provisions such as the Qualified Entity data-sharing program reflects Congress's intent to minimize "information silos" in the health care sector and to spur broader data sharing as a means of facilitating delivery and payment system reform at the federal and state levels, and in the private health care sector.

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[15] Insurers may not receive such analyses from Qualified Entities unless they are providing the Qualified Entity with their own claims data. MACRA §§ 105(a)(1)(B)(ii) & (9)(A)(iv).

In further recognition of the importance of the states' role in reform as laboratories of innovation, Congress authorized HHS's Centers for Medicare & Medicaid Services ("CMS") to establish the State Innovation Models initiative under Affordable Care Act § 3021. Social Security Act, §1115A(b)(2)(B)(xi), 42 U.S.C. § 1315a. The State Innovation Models program allows CMS to award grants to states to design and test innovative, state-based multi-payer health care delivery and payment systems that will foster broader innovation and health system transformation to improve population health across communities covered by both public and private payers.

A central premise of the State Innovation Models grant program is that states are in the best position to enlist all stakeholders in the community in contributing to public and private reform efforts. In its announcement of cooperative agreement funding opportunities for "Round 1" State Innovation Models grants in August 2012, CMS's Center for Medicare & Medicaid Innovation (the "Innovation Center") declared:

> States are key partners in developing and testing community-centered health systems and proving that they can deliver significantly improved cost, quality, and population health performance results for Medicare, Medicaid, and CHIP beneficiaries. States have policy and regulatory authorities, as well as ongoing relationships with private payers, health plans, and providers, that can help drive and accelerate performance of payment and service delivery models

> across the spectrum of public and private payers. The Innovation Center intends to provide States with funding to design and test models that use the full range of their policy authorities and their ability to convene a broad array of stakeholders, both private and public, to enhance and accelerate the development of innovative health system models that result in better health, better care and reduced costs through improvement.

CMS, Center for Medicare & Medicaid Innovation, *State Innovation Models: Funding for Model Design and Testing Assistance* 2, Cooperative Agreement, Amended Announcement, Funding Opportunity No. CMS-1G1-12-001 (Aug. 23, 2012), *available at* http://innovation.cms.gov/Files/x/StateInnovation_FOA.pdf; *see also* Amanda Van Vleet & Julia Paradise, Kaiser Family Found., *The State Innovation Models (SIM) Program: An Overview* (Dec 09, 2014), *available at* http://kff.org/medicaid/fact-sheet/the-state-innovation-models-sim-program-an-overview/.

Vermont's "Blueprint for Health" is an example of the very type of state-led innovation effort the State Innovation Models program is designed to encourage. Vermont was among the first six states to receive a State Innovation Models grant. *See* CMS, *State Innovation Models Initiative: General Information*, http://innovation.cms.gov/initiatives/state-innovations/ (last visited Sept. 3, 2015). Vermont law defines the "Blueprint" as a "program for integrating a system of health care for patients, improving the health of the overall population, and improving con-

trol over health care costs by promoting health maintenance, prevention, and care coordination and management." S. 88, 2009-2010 Sess. (Vt. 2010) (amending Vt. Stat. Ann. Tit. 18, ch. 13).

The Affordable Care Act also reflects Congressional intent that states have adequate means to perform their traditional regulatory role of evaluating health care premium rate increases. Affordable Care Act § 1003 directed the HHS Secretary, "in conjunction with the States," to establish a process for annually reviewing health insurers' rate increases. 42 U.S.C. § 300gg-94. To strengthen states' rate review processes, the Affordable Care Act provided $250 million in grants to enhance states' conduct of "vigorous reviews that assure cost estimates use verifiable medical trend data and realistic administrative cost projections." CMS, *Rate Review Works: Early Achievements of Health Insurance Rate Review Grants*, *available at* https://www.cms.gov/CCIIO/Resources/Files/Downloads/rate_review_report_092011.pdf; *see also* Sabrina Corlette et al., Georgetown Univ.'s Health Policy Inst., *Cross-Cutting Issues: Monitoring State Implementation of the Affordable Care Act in 10 States: Rate Review* (Sept. 1, 2012).

Forty-three states, including Vermont and the District of Columbia, have received rate review grants. CMS, Ctr. for Consumer Info. & Ins. Oversight, *State Effective Rate Review Programs*, https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html (last visited Sept. 3, 2015). Data that reflects a broad cross-section of health care consumers, including the significant segment of individuals, and their families,

covered by employer-sponsored self-funded plans, is an important success factor of these federally-funded rate review programs. *See id.* (explaining that in the course of rate reviews, states should consider, among other factors, cost trends and changes in utilization).

B. The States Have A Long History Of Aggregating Health Data To The Benefit Of Their Citizens.

States have long collected, aggregated, and analyzed a wide variety of health data in order to carry out their population health responsibilities. Examples of such data historically have included disease registry data; vital statistics and demographic data; coroners' reports; clinical laboratory utilization and test results; reports of disease, epidemic, and individual case investigations; data on hospital and post-acute care admissions, lengths-of-stay, and discharges; health care facility survey data; injury and occupational illness data; school absentee data; and information on potential disease vectors and contamination sources in the local environment. Univ. of Ill. at Chi., School of Public Health, *Principles of Epidemiology Course, Lesson 5 Public Health Surveillance*, *available at* http://www.uic.edu/sph/prepare/courses/ph490/resources/epilesson05.pdf.

For over a decade, a growing number of states have recognized that a key element in improving overall population health is understanding the cost, quality, and utilization of health care for their residents by harnessing the valuable information contained in payers' claims and eligibility data. The move toward using claims data to inform quality im-

provement and cost containment efforts began in earnest when Maine established the first statewide APCD in 2003. By the end of 2008, Kansas, Maryland, Massachusetts, and New Hampshire also had established APCDs. By the end of 2010, Minnesota, Tennessee, Utah, and Vermont had enacted legislation to create their own APCDs. Jo Porter et al., Robert Wood Johnson Found., *The Basics of All-Payer Claims Databases: A Primer for States* (January 2014), *available at* https://www.nahdo.org/sites/nahdo.org/files/publications/The%20Basics%20of%20All-Payer%20Claims%20Databases.pdf.

At present, more than thirty states have established, are implementing, or have expressed strong interest in comprehensive, multi-payer databases. *Id.* These databases may include private health insurers' claims, along with data from Medicaid, children's health insurance and state employee health benefit programs, prescription drug plans, dental insurers, and employer-sponsored self-funded plans with Medicare claims data now becoming available through the Qualified Entity program (and CMS's other programs that permit sharing Medicare data with state agencies).[16]

While enormously valuable for studying health care cost, utilization, and other population health issues, claims data stand in contrast to the detailed clinical information, including physician notes, as found in electronic health records. These claims data aggregation programs further protect individual pri-

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[16] *See supra* Section III.A regarding the Qualified Entity program.

vacy by following strict data protection and data release governance protocols, including the use of binding data use agreements. *See, e.g.*, 10 Colo. Code Reg. 2505-5, § 1.200.5 (requiring HIPAA adherence and implementation of a multi-stakeholder data release review committee to advise Colorado's APCD regarding data release requests).

C. Private Sector Health Data Initiatives Demonstrate Feasibility But To Date Provide An Incomplete View.

A wide variety of health care performance data is available from a number of sources, including state and federal agencies, national accrediting bodies, research groups, professional associations, health plans, employers, vendors that aggregate data from multiple plans or employers, and organizations such as the California Public Employees' Retirement System ("CalPERS"), the Pacific Business Group on Health, the Leapfrog Group, Health Action Council Ohio, the New Hampshire Purchasers Group on Health, and the Maine Health Management Coalition. The Leapfrog Group, for example, collects and publishes quality and safety measure data, endorsed by the National Quality Forum, from over 1,500 hospitals that voluntarily participate in its surveys. Leapfrog Group, *LHRP Details for Hosps.*, http://www.leapfroggroup.org/Hospitals/Competitive Benchmarking/4751817. In many parts of the country, local health care coalitions are starting to collect and report physician performance data derived from networks of local health plans, employers, and physician organizations. Gordon Mosser et al., Network for Reg'l Healthcare Improvement, *Regional Coali-*

tions for Healthcare Improvement: Definition, Lessons, and Prospects 18, *available at* http://www.improvingchroniccare.org/downloads/nrhi.pdf.

The Health Care Cost Institute ("HCCI"), a nonprofit organization with nationwide research objectives, is undertaking some of the more ambitious private sector initiatives to gather and leverage health care claims data. HCCI, *About HCCI*, http://www.healthcostinstitute.org/about (last visited Sept. 3, 2015). Through research and access to large payer claims data sets, HCCI seeks to offer answers to critical questions about health care spending and utilization. Demonstrating the value created by collaboration between such private efforts and statewide APCDs, last year HCCI published a report analyzing health care trends of employer-sponsored insured Vermonters younger than 65 and comparing them with national patterns, using data provided by Vermont's APCD. HCCI, *2007-2011 Vermont Health Care Cost and Utilization Report, Executive Summary* 1, *available at http://www.healthcostinstitute.org/files/2007-2011VermontHCCUR_DecemberRevision%2012-11-14.pdf.*

Efforts such as these are important contributors as the country shifts to value-based purchasing, and should be encouraged.[17] However, these national ef-

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[17] HCCI's database of claims and eligibility data does include data attributable to persons covered by employer-sponsored self-funded plans. However, it is unclear whether this model may be executed more broadly given that the sources of this data are primarily large national health insurance carriers that have funded HCCI and that also act as third-party administra-

forts on the part of payers do not include sufficient population in many individual states to permit state-specific analyses. The private organizations also can have limited ability to release financial data, given disclosure prohibitions in the data submission agreements that are part of the voluntary nature of their structure. Moreover, private sector efforts do not obviate the need for mandatory submissions from all payers in the marketplace—including, employers—to meet states' broader population health responsibilities and their key role in cost containment. State-mandated APCDs that aggregate fully-insured and employer-sponsored self-funded claims, as well as Medicaid and Medicare data, are essential to providing the most comprehensive picture possible so that states such as Vermont may achieve the public health missions their legislators have assigned them, *e.g.*, to assess "the capacity and distribution" of health care resources in the state, inform health care policy, evaluate the effect of intervention programs on improving patient outcomes, compare "costs between various treatment settings and approaches," provide information to consumers and purchasers, and improve "the quality and affordability of patient health care and health care coverage." Vt. Stat. Ann. tit. 18, § 9410(a)(1) (Pet. App. 92).

CONCLUSION

For these reasons, the Second Circuit decision should be reversed.

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tors for such self-funded plans. *See* financial statements presented at http://www.healthcostinstitute.org/about.

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IN THE

Supreme Court of the United States

ALFRED GOBEILLE, IN HIS OFFICIAL CAPACITY AS CHAIR OF THE VERMONT GREEN MOUNTAIN CARE BOARD,
Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF *AMICUS CURIAE* OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS IN SUPPORT OF RESPONDENT

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On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF *AMICUS CURIAE* OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS IN SUPPORT OF RESPONDENT

The National Coordinating Committee for Multiemployer Plans ("NCCMP") is a nonprofit, tax exempt organization that has participated for over thirty years in the development of employee benefits legislation and regulations promulgated to implement the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, and other laws affecting multiemployer plans.[1] The NCCMP's

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[1] Counsel for both the Petitioner and the Respondent have filed with the Clerk of this Court blanket consents to the filing of *amicus curiae* briefs. Pursuant to Rule 37.6 of the Rules of this

primary purposes are to assure an environment in which multiemployer plans can continue their vital role in providing medical, pension, and other benefits to working men and women, and to participate in the development of sound employee benefits legislation, regulations, and policy.

The NCCMP is the only national organization devoted exclusively to protecting the interests of multiemployer plans by advocating on behalf of these plans in Congress, in the courts, and in the regulatory process. Multiemployer plans provide benefits to tens of millions of American workers. Hundreds of multiemployer plans and related organizations, with a nationwide participant base, are affiliated with the NCCMP. Affiliated plans are active in every segment of the multiemployer plan universe, including the airline, building and construction, entertainment, food production, distribution and retail sales, health care, hospitality, mining, maritime, industrial fabrication, service, textile, and trucking industries. Congress has recognized that the continued well-being and security of employees, retirees, and their dependents are directly impacted by multiemployer plans and that interference with the maintenance and growth of such plans is contrary to the national public interest. *See* 29 U.S.C. § 1001a(a)(1), (3), (c)(2).

The Vermont health care database statute, Vt. Stat. Ann. tit. 18, § 9410 ("Act"), imposes significant burdens on self-funded multiemployer health plans

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Court, the undersigned hereby state that no counsel for Petitioner or Respondent authored any part of this brief. Moreover, no person or entity other than the NCCMP made a monetary contribution to the preparation or submission of this brief.

throughout the country, regardless of where they are based, so long as they have 200 participants and beneficiaries who reside and/or receive medical treatment in Vermont. The Act imposes extensive record-keeping and reporting obligations regarding health care claims and subjects plans to administrative oversight by the State. These obligations intrude on the core functions of employee health plans, an exclusively federal sphere of regulation under ERISA. Allowing the State of Vermont to overlay its own requirements upon the comprehensive, and exclusive, scheme of federal administration of ERISA plans will significantly burden trustees and plan administrators in performing their ERISA-mandated functions of reporting and disclosure.

If Petitioner's position prevails, the result will be to impair the historical ability of multiemployer health plans to operate under "a uniform body of benefits law," thereby undermining the goal of ERISA preemption "to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). Furthermore, if the Petitioner's position prevails, the door will be wide open for other states to impose their own additional requirements on the essential plan functions of reporting and disclosure.[2] A multiplicity of incompatible and varying demands will place increasing stress on the administra-

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[2] Although certain other states have enacted health care data collection legislation, several do not currently require information from self-insured ERISA plans. *See* J.A. 207- 216, Summary Table of State Health Reporting Laws.

tion of plans and will force plan fiduciaries to divert plan assets from their exclusive statutory purpose: "providing benefits to participants and beneficiaries; and . defraying reasonable expenses of administering the plan." 29 U.S.C. § 1104(a)(1)(A). This will come at huge expense to the plans, a cost which will ultimately be reflected in the benefit levels payable to participants and beneficiaries. The NCCMP submits that such a result cannot be reconciled with the statutory requirement of reasonableness.

Accordingly, the NCCMP and its constituent groups have a strong interest in supporting affirmance of the decision below. The NCCMP believes that the Second Circuit's decision properly ensures that multiemployer plans will retain their rights, guaranteed under ERISA's express preemption provision, to maintain a uniform administrative scheme for reporting and disclosure and, by extension, fulfill the statute's requirement to efficiently administer the plans. The NCCMP urges this Court to enforce ERISA's broad preemption provision and to ensure that the core functions of ERISA plans continue to be subject exclusively to federal regulation.

INTRODUCTION

The question in this case is whether ERISA's express preemption provision continues to have the teeth that the statute itself, and this Court's interpretation of the statute, provide. ERISA's preemption provision is extremely broad: ERISA "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). This Court has explained that

ERISA preempts "state laws that mandate employee benefit structures or their administration." *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995). In *Travelers*, the Court described certain ways in which ERISA comprehensively regulates plan administration, preempting state laws. "The federal statute . . . controls the administration of benefit plans, as by imposing reporting and disclosure mandates, participation and vesting requirements, funding standards, and fiduciary responsibilities for plan administrators." *Id.* at 651 (internal citations omitted) (citing provisions of the statute). While the outer limits of ERISA preemption may be undefined, reporting and disclosure are its bread and butter. The Court has stated in no uncertain terms that "state laws dealing with the subject matters covered by ERISA[,] reporting, disclosure, fiduciary responsibility, and the like," are unquestionably preempted. *Id.* at 661 (alterations in original) (quoting *Shaw v. Delta Air Lines*, 463 U.S. 85, 98 & n.19 (1983)).

And with good reason. A principal goal of ERISA was to enable plan sponsors to establish a nationally uniform administrative scheme for processing claims and disbursing benefits. *See Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 9 (1987). In order to operate, plans determine the information they need to be able to process claims, disburse benefits, and comply with federal reporting requirements. Plans develop systems tailored to meet those needs and carefully collect and maintain the information. Because many multiemployer plans are regional, if not national, in scope, uniformity among the states with regard to collection, reporting, and disclosure re-

quirements is critical to efficient plan administration. As this Court has recognized, such uniformity is impossible if plans are subject to different legal requirements in different parts of the country. *Egelhoff v. Egelhoff ex. rel. Breiner*, 532 U.S. 141, 148 (2001). Accordingly, different state regulations upending an ERISA plan's reporting and disclosure requirements "impose 'precisely the burden that ERISA preemption was intended to avoid.'" *Id.* at 150 (quoting *Fort Halifax*, 482 U.S. at 10).

Trustees and administrators of multiemployer plans, including those affiliated with NCCMP, heavily rely on ERISA's guarantee of national uniformity in their claims processing systems and recordkeeping and reporting requirements. Multiemployer plans are not profit-making entities. They are the product of the collective bargaining process, and they serve as a vehicle for providing health benefits for working men and women and their families. Often, the participants in the plans work in industries characterized by physically demanding work, such as construction and related crafts, which leads to more medical claims than in other industries. The plans' survival is conditioned upon the parties' ability to negotiate agreements which meet the wage and benefit requirements of workers while enabling their employers to remain profitable, allowing the employers to provide jobs and the benefits which are a byproduct of such employment and the focus of this case. Requiring multiemployer plans to capture data which they have no need to collect in order to fulfill their claims processing, benefits-providing functions, and then to record and report such data in accordance with each state's desires, will di-

vert plan assets from the employee benefits that the plans exist to provide.

Multiemployer plans are run by joint boards of trustees appointed by participating employers and labor organizations. Trustees are, therefore, acutely aware of the limited ways in which plans can keep up with ever-increasing health care costs: employers can contribute more money toward the plans, which may make the cost of their products or services less competitive in the market; employees can take cuts in pay; or plans may be forced to make cuts in benefits.

ERISA requires that plan assets be held in trust for the exclusive purpose of providing benefits to participants and beneficiaries and defraying the reasonable expenses of administering the plans. 29 U.S.C. § 1103. For multiemployer plans in particular, it is critical that every possible penny go to the payment of benefits. Petitioner neither considers these realities nor acknowledges the underlying reach of ERISA preemption. If Petitioner prevails, it will directly and significantly impact multiemployer plans' core functions under ERISA—claims processing, reporting, disclosure, and recordkeeping—at the expense of plans' abilities to provide adequate benefits to their participants and beneficiaries.

SUMMARY OF THE ARGUMENT

The Court of Appeals properly held that the Vermont Act is preempted under Section 514 of ERISA, 29 U.S.C. § 1144, because, by establishing detailed and onerous reporting and disclosure requirements for health care

claims, it impermissibly relates to self-funded employee benefit plans. The Vermont Act regulates a subject matter expressly covered by ERISA: plan reporting and disclosure. This Court has repeatedly held that reporting and disclosure requirements are a function of plan administration, and that state laws imposing mandates on plan administration are preempted because they frustrate ERISA's essential goals of national uniformity, as well as efficiency and cost effectiveness, in the administration of ERISA plans. The lower court's decision, therefore, followed the Court's holding in *Travelers* and other precedent and should be affirmed.

The data collection, recordkeeping, and reporting requirements of the Vermont Act strip multiemployer plans of the protections of uniform federal law. The Act requires collection of hundreds of data elements for member eligibility and health care claims, including scores of elements which must be captured on a claim-by-claim basis, thus requiring self-insured multiemployer plans with participants or beneficiaries living in or receiving health care in Vermont to adopt different, additional procedures for collecting data on health care claims. The Act also mandates that multiemployer plans establish special recordkeeping procedures relating to claims, thus requiring plans to adopt different, and additional, recordkeeping procedures in Vermont that apply nowhere else in the country. The Act forces plans to report all of this data in strict compliance with meticulous coding, encrypting, formatting, and filing requirements, which again apply only in Vermont. Finally, the Act vests state agencies with administrative oversight over aspects of paid claims, thus subjecting ERISA plans with a Vermont connection to both federal and state enforcement schemes.

If the decision below is overturned it will significantly weaken ERISA preemption, opening the door for every state to impose its own invasive requirements on plan administration. It is contrary to the national interest to allow the states to trigger the imposition of such a substantial administrative burden and expense on hundreds of self-insured multiemployer plans.

ARGUMENT

I. THE VERMONT STATUTE IMPOSES HEAVY BURDENS ON MULTIEMPLOYER PLANS, CONTRARY TO ERISA'S CENTRAL AIM OF ALLOWING PLANS TO OPERATE UNDER A NATIONALLY UNIFORM SYSTEM OF ADMINISTRATION.

Petitioner argues that the Vermont Act should not be preempted because it regulates an area—reporting and disclosure—where "ERISA has nothing to say." Pet'r Br. 25, 30 (quoting *Travelers*, 514 U.S. at 661; *Cal. Div. of Labor Standards Enf't v. Dillingham Constr., Inc.*, 519 U.S. 316, 330 (1997)). But *Travelers*, the primary case Petitioner cites for this proposition, expressly recognizes that ERISA does have something to say about reporting and disclosure, recognizing that state laws are preempted when they "deal[] with the subject matters covered by ERISA, *reporting*, *disclosure*, fiduciary responsibility, and the like." *Travelers*, 514 U.S. at 661 (citation omitted) (emphasis added); *see also*, *e.g.*, 29 U.S.C. §§ 1021-1031 (addressing plans' reporting, recordkeeping and disclosure obligations to the Department of Labor). As the decision below correctly noted, reporting and disclosure are matters of plan administration, and "'state statutes that man-

date employee benefit structure *or their administration*' have a 'connection with' ERISA plans and are therefore preempted." *Liberty Mutual Ins. Co. v. Donegan*, 746 F.3d 497, 507 (2d Cir. 2014) (quoting *Dillingham*, 519 U.S. at 328) (emphasis added by Second Circuit).

Certain laws that "creat[e] no impediment to [a plan's] adoption of a uniform benefit administration scheme" **might** survive a preemption challenge. *Fort Halifax*, 482 U.S. at 14; *see also Shaw*, 463 U.S. at 100 n. 21 (finding no preemption when a state statute has "too tenuous, remote, or peripheral" an effect on employee benefit plans). The Vermont Act, however, creates impediments which are neither tenuous, remote nor peripheral. It imposes painstaking and stringent data collection, recordkeeping, and reporting requirements on multiemployer plans, inflicting impermissible mandates on plan administration. Accordingly, it is preempted.

A. The Vermont Act's Data Collection Requirements Impose a Mandate on Plan Administration.

The Act and its accompanying regulations require plans to report "healthcare claims data" in minute detail for members who reside or receive health care services in Vermont. Vt. Stat. Ann. tit. 18, § 9410(b), (j)(1); Vt. State Reg. H-2008-01, §§ 1, 3.Q, 3.X, 3Ab. The regulations contain over twenty pages of appendices, which list hundreds of data elements plans must provide regarding member eligibility as well as the details of each health care claim. *See id.* H-2008-01, Appendices B-1 through D-1; J.A. 155-177. Pro-

viding partial data is not enough. The State's official guidance instructs that "[s]ubmissions with data elements failing the completeness threshold for one or more fields will be rejected in their entirety." J.A. 134 (Vermont Frequently Asked Questions (FAQs) for the Collection of Commercial Claims Data, Answer 13). And if a plan fails to provide data required by the Act, the State may impose fines of up to $10,000 per violation. *See* Vt. Stat. Ann. tit. 18, § 9410(g).

Contrary to Petitioner's bald assertion, multiemployer plans do not in each instance "already . . generate" this data "in the ordinary course of business." Pet'r Br. 4. This statement proceeds from the mistaken assumption that self-funded multiemployer plans function like health care providers. They do not. Multiemployer plans exist solely to administer a plan of benefits to their participants: working men and women, retirees, and their dependents and beneficiaries. Plans, especially smaller plans, are not in the business of big data. To the contrary, they seek to preserve plan assets and to reduce resources spent on data entry, storage and management to the minimum necessary to process claims, disburse benefits and comply with national recordkeeping and reporting requirements. ERISA's broad preemption provision, intended to protect plans from conflicting and multiplicative state regulation, was enacted to "minimize the administrative and financial burden" on plans. *Ingersoll-Rand*, 498 U.S. at 142.

Many multiemployer plans are self-funded and self-administered, and work with a variety of vendors who provide different levels of administrative services for mental/behavioral, prescription, dental, and medical benefits. In addition to different claims forms and ad-

ministrative paperwork for each of these types of benefits, a plan may also have to process claims both within and outside of the plan's networks of providers, which again may vary based on the type of benefit. Because of the variety and complexity of data provided to the plans, many plans create proprietary software which contains only the information needed to properly adjudicate claims in accordance with the plan of benefits and to meet ERISA's reporting requirements.

As a result, many of the NCCMP's constituent plans likely capture only about 70-80% of the data required by the Vermont Act. For example, these plans may have no reason, ability, or need to capture inpatient admission hour, type, source, discharge hour, or status, as required in Appendix D-1 to the regulations, data fields M-019 through 023. J.A. 167-68. Plans may not capture or record service provider specialty, type of bill, or site of service, particularly at the level of specificity required by the Act. J.A. 169-72 (Appendix D-1, M-032, M-036, M-037). And plans may not obtain or use Diagnostic Code Related Groupings ("DRG") codes, DRG versions, Ambulatory Patient Classifications ("APC"), or National Drug Code ("NDC") information as mandated by the Act. J.A. 176 (Appendix D-1, MC-071 through 075). These plans simply have no need for this information in order to fulfill their claims processing, benefits-providing functions, nor do they need it to comply with federal law. They therefore do not collect it.

Compliance with the Vermont reporting scheme would force self-funded plans to alter their claims data gathering procedures, a function integral to the administration of the plans. These mandated changes would

require plans to seek different and additional information from various providers, vendors and third parties with whom they work, forcing significant changes to their claims recording and processing software, and imposing new costs for the input of more data. For plans that are self-funded and self-administered, the cost of such changes is shouldered directly by the plan. For plans that contract with a third party administrator ("TPA"), the TPA pays the initial costs, then seeks reimbursement from the plan directly or passes the costs along to the plan indirectly by raising its fees or cutting other services.[3] Either way, the costs are ultimately borne by the participants and beneficiaries in the form of reduced benefit levels or more money taken from their wages to maintain current benefit levels.

B. The Vermont Act's Recordkeeping Requirements Permit the State to Interfere with Plans' Core Functions, Contrary to ERISA's Express Preemption Provision.

Separate and apart from requiring multiemployer plans to capture data elements which they would not otherwise collect, the Act also forces plans to alter

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[3] As the facts of this case illustrate, a multiemployer plan with a TPA may be subject to the cost of compliance with the Vermont Act even if the plan has fewer than two hundred covered members residing or receiving services in the state of Vermont. *See Liberty Mutual*, 746 F.3d at 501-02 (although Liberty Mutual only provided benefits to 137 individuals in Vermont, its data was subject to the Act because its TPA qualified as a mandatory reporter). If all the plans the TPA serves meet the 200 person threshold in the aggregate, the TPA will be subject to the Act and will almost certainly pass those costs on to the plan.

their recordkeeping functions to conform to Vermont's protocol.

For example, the Act requires plans to maintain separate—and previously unnecessary—records based on the residency of participants and their eligible dependents, and the location of the provider. *See, e.g.*, Vt. Stat. Ann. tit. 18, § 9410(b), (j)(1); Vt. State Reg. H-2008-01, §§ 1, 3.Q, 3.X, 3Ab. This leaves multiemployer plans with a number of practical difficulties. First, unlike an employee benefit plan sponsored by a single Vermont employer, where most participants, beneficiaries and providers are located in the State, many large multiemployer plans have a regional or nationwide base of employers, participants, beneficiaries, and medical providers. Second, some health care providers contract with out of state billing agencies. Adding to the confusion, billing arrangements may provide for payment to be remitted to yet a different address, leading to the complicated—but not unusual—situation in which a participant gets sick in Vermont and the plan receives a bill from New Jersey with instructions to remit payment to a post office box in Ohio. Third, NCCMP constituent plans cover many employees in the building and construction trades and those in the maritime and trucking industries, who commonly travel out of state to work for either limited or extended periods of time. Thus, a participant may live temporarily, work and receive needed medical treatment in one state, while his or her family members continue to reside and receive medical treatment in Vermont. Fourth, with the extension of dependent coverage to age twenty six under the Affordable Care Act, many plans cover adult children residing in other states while they work or attend school. Under each

of these circumstances, the Vermont Act requires multiemployer plans to determine, and to keep records of, where each medical service was rendered and for which member of the family, and to pair this information with each person's domicile. Nothing in ERISA requires plans to maintain these records or to configure them in this fashion;[4] accordingly, plans subject to the Act are forced to revise their claims-processing procedure to maintain separate claims-based records for residents of Vermont and for all services provided in Vermont. These superimposed recordkeeping obligations make uniformity of plan administration impossible to achieve and frustrate the purpose of Congress in legislating ERISA preemption.

C. The Vermont Act's Reporting Obligations Place an Unacceptable Administrative Burden on Multiemployer Plans to the Detriment of Plan Participants.

Petitioner suggests that the information requested by the Act "may be transmitted with a few key

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[4] ERISA requires plans to maintain records and file reports to support their expenditures, including the Form 5500 Series (the form itself and multiple schedules), in order to satisfy the annual reporting requirements set forth in 29 U.S.C. §§1023 and 1024. *See* Form 5500 Series, *available at* http://www.dol.gov/ebsa/5500main.html. While these forms and schedules require a tremendous amount of information, including the total amount of claims paid annually by the plan, nothing in ERISA requires plans to either compile or report information on a state-by-state basis, much less on the granular claim-by-claim basis required by the Vermont Act. *Id.* More fundamentally, ERISA does not require plans to track the location of services rendered at all.

strokes." Pet'r Br. 55. Even assuming that plans already captured and recorded the information required by the statute and in the form required by the statute, which as discussed *supra* they do not, this statement is simply untrue. Petitioner and particularly his *amici* cite the All-Payer Claims Database ("APCD") Council, an all-payer database advocacy group, for the purported benefits of all-payer claims databases. *See, e.g.*, Pet'r Br. 32; Brief of *Amici Curiae* American Medical Ass'n and Vermont Medical Society 11-12; Brief of *Amici Curiae* National Governors Ass'n et al. 14-16. However, the APCD Council itself admits that "each state is collecting different data by different methods and with different definitions." J.A. 219 (Amy Castello & Mary Taylor, APDC Council, *Standardization of Data Collection in All-Payer Claims Databases* (Jan. 2011)); *see also* APCD Council, *All-Payer Claims Database Development Manual* at 7 (Mar. 2015), *available at* https://www.apcdcouncil.org/file/29/download?token=EoozDsLJ (recognizing ongoing "payers' burden" to submit different data, to different states, in different formats). The Council recognizes that as these databases "are required in more states, the cost to payers will become significant," as will "the challenges for payers to provide the required data." J.A. 220. "Payers need a minimum of nine months to make systems changes and program the initial . . data sets," in the form and structure required for a state's data submission. J.A. 221. By Petitioner's and *amici*'s own advocacy group's admission, the reporting requirements attendant to all-payer claims databases impose significant burdens on plans.

The Vermont Act's reporting requirements are detailed and exhaustive. The Act requires plans or their TPAs to file monthly, quarterly or annual submissions with the State depending on the number of covered members residing or receiving services in Vermont, regardless of whether the plans are based in the State. *See, e.g.*, Vt. Stat. Ann. tit. 18, § 9410(b), (j)(1); Vt. State Reg. H-2008-01, §§ 1, 3.Q, 3.X, 3Ab. It grants broad authority to the Vermont Green Mountain Care Board to require plans to submit "information determined by the Board to be necessary," and to establish "the time and place and the manner in which such information shall be filed." *Id.* § 9410(c), (d).

As set forth above, the regulations and their appendices require plans to report hundreds of data fields, including scores of fields for each individual claim. Completion of some of these data fields requires plans to obtain certain prior approvals from a State administrative body charged with implementing and enforcing the law. For example, multiemployer plans do not fit within one of the prescribed categories for the "Coverage Type" or "Market Category Codes" fields, and may not report using the "other" code without prior approval from the State. *See* J.A. 161-62 (Appendix D-1, ME029 through ME030).

In addition to the sheer volume of data to be reported, the Act and its regulations contain onerous requirements for the manner in which the reports must be filed. The data must be coded, encrypted, contain the correct file specifications, headers and trailers, and formatted in microscopic detail. *See, e.g.*, Vt. State Reg. H-2008-01 § 5(A)(1)-(16), 5(B)(1)–(4)(c)(2). The complexity inherent in the Act's re-

porting systems is clearly illustrated by one piece of State guidance: Vermont's Frequently Asked Questions for the Collection of Commercial Claims Data, which contains fifty-five questions not including subparts. J.A. 122-154. As the State makes clear, failure to comply with any of these requirements may cause the plan's entire data submission to be rejected. *See* J.A. 146-149 (FAQ, Answer 37.a – 37.l) (listing the twelve "most common" reasons for rejection). Failure to comply with the Act subjects plans to State enforcement mechanisms, including "investigation, subpoena, fine[s]," of up to $10,000 per violation, or "other legal and equitable remedies." Vt. State Reg. H-2008-01 §10.

The Court below examined the burdens imposed by the Act and correctly concluded that "even considered alone, the Vermont scheme triggers preemption; considered as one of several or a score of uncoordinated state reporting regimes, it is obviously intolerable." *Liberty Mutual*, 746 F.3d at 509. In view of the trend toward states establishing health care databases, a proliferation of state laws imposing incompatible and varying demands on ERISA plans is not merely hypothetical: it is imminent.

CONCLUSION

For the foregoing reasons, the NCCMP respectfully urges the Court to affirm the decision of the Court of Appeals.

Respectfully submitted,

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No. 14-181

IN THE

Supreme Court of the United States

ALFRED GOBEILLE, in his Official Capacity as Chair of the Vermont Green Mountain Care Board,
Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF FOR *AMICI CURIAE* NATIONAL GOVERNORS ASSOCIATION, NATIONAL CONFERENCE OF STATE LEGISLATURES, COUNCIL OF STATE GOVERNMENTS, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, AND ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS, IN SUPPORT OF PETITIONER

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INTEREST OF *AMICI CURIAE*[1]

Amici are organizations whose members include state governments and officials from across the country. *Amici* regularly file briefs in matters like this one, which raise issues of concern to the Nation's States.

The National Governors Association ("NGA"), founded in 1908, is the collective voice of the Nation's governors. NGA's members are the governors of the fifty States, three Territories, and two Commonwealths.

The National Conference of State Legislatures ("NCSL") is a bipartisan organization that serves the legislators and staffs of the Nation's fifty States, its Commonwealths, and Territories. NCSL provides research, technical assistance, and opportunities for policymakers to exchange ideas on the most pressing state issues. NCSL advocates for the interests of state governments before Congress and federal agencies, and regularly submits *amicus* briefs to this Court in cases, like this one, that raise issues of vital state concern.

The Council of State Governments ("CSG") is the Nation's only organization serving all three branches of state government. CSG is a region-based forum that fosters the exchange of insights and ideas to help state officials shape public policy. This offers unparalleled regional, national, and international opportunities to network, develop leaders, collaborate, and create problem-solving partnerships.

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[1] No party or counsel for a party authored this brief in whole or in part. No party, counsel for a party, or person other than the *amici curiae* or their counsel made a monetary contribution intended to fund the preparation or submission of this brief. Petitioner and Respondent have filed blanket consents to the filing of *amicus curiae* briefs in this case.

The National Association of Insurance Commissioners ("NAIC"), founded in 1871, is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate regulatory oversight. The NAIC members, together with the centralized resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

The Association of State and Territorial Health Officials ("ASTHO") is the national nonprofit organization representing public health agencies in the United States, the U.S. Territories, and the District of Columbia, and over 100,000 public health professionals these agencies employ. ASTHO members, the chief health officials of these jurisdictions, formulate and influence sound public health policy and ensure excellence in state-based public health practice. ASTHO's primary function is to track, evaluate, and advise members on the impact and formation of public or private health policy which may affect states and to provide them with guidance and technical assistance on improving the nation's health.

This case directly impacts the interests of *amici* and their members. States across the country—through members of the *amici* organizations, which include the governors, legislatures, insurance commissioners, public health officials, and other state officials—are working to ensure that citizens have access to quality and affordable health care services. This is a task for which states have traditionally been responsible—rising to the level of an "historic police power." In an effort to better understand the provision of health care

services, track related expenses and provide transparency to consumers, providers, and payers, many states have implemented databases similar to the one established by Vermont. States have long-relied on the assumption that the federal government would not interfere with their historic police powers in the field of health care policy. In implementing these databases, states depend on the strong presumption against ERISA preemption to guarantee they are collecting complete and reliable data from *all* health care service payers. *Amici*, thus, have a strong interest in the outcome of this case.

SUMMARY OF ARGUMENT

Eighteen states, including Vermont, collect and analyze health care claims data to regulate the safe and effective provision of health care services. The data collected provides states with critical information about the health of their citizens and contributes to their understanding of health care utilization, cost, and quality. The information gathered can be used for a variety of purposes, allowing consumers to shop for the lowest cost and highest quality care, insurers to negotiate acceptable rates, and lawmakers to establish tailored health care policy initiatives. But without data from *all* health care payers, including self-insured plans (which cover nearly 70 million participants) the completeness, and therefore usefulness, of the data would be compromised.

ERISA does not preempt these health care data collection laws. In enacting these laws, states are exercising their historic and traditional police power to ensure the health and safety of their citizens. Accordingly, this Court should apply the presumption against preemption to these laws. Liberty Mutual has provided no evidence to overcome this presumption.

These laws apply generally to *all* health care payers and do not relate to ERISA plans. They do not interfere or conflict with the "reporting" required by ERISA, which is predominantly concerned with the financial solvency of the plans and not the health care outcomes of their beneficiaries. Additionally, there is no indication that Congress meant to supersede these types of laws, particularly in light of a federal law enacted only months after ERISA encouraging states to seek much of the same data collected by Vermont and other states. Furthermore, the state data collection laws do not mandate benefit structures or administration, nor do they provide an enforcement mechanism. And while there may be incidental costs involved with providing the data, these costs alone do not render a state law preempted by ERISA.

The Second Circuit misapplied long-standing ERISA preemption case law. Left uncorrected, this ruling will negatively impact health care policy across the country.

ARGUMENT

I. ERISA Preemption is Inappropriate

This Court repeatedly has held that there is a presumption that Congress does not intend to supplant state law, particularly in areas of traditional state regulation. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655, 657 (1995); *California Div. of Labor Standards Enforcement v. Dillingham Const., N.A., Inc.*, 519 U.S. 316, 334 (1997); *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806, 814-15 (1997). In the case below, the Second Circuit rejected this presumption, confining its analysis to a footnote in which it concluded, without citation, that the "state

data collection laws do not regulate the safe and effective provision of health care services, which is among the states' historic police powers." *Liberty Mut. Ins. Co. v. Donegan*, 746 F.3d 497, 506 n.8 (2d Cir. 2014), *cert. granted sub nom. Gobeille v. Liberty Mut. Ins. Co.*, 135 S. Ct. 2887 (2015). The *amici* joined in this brief disagree with this conclusion and defend the legitimate use of state police powers to collect health care data.

A. Health Care Data Collection Laws Fill Critical Information Gaps for States

States are regulators, suppliers, payers and customers of the health care delivery system. States need access to high quality, consistently-collected data reflecting health care use to support effective health policy development, understand health system use, and drive health delivery reform. Unsurprisingly, for many years, states have been innovators in data collection to support these health care improvement efforts.

Historically, state health care data collection has been limited. Currently, most states maintain: state-based hospital discharge systems;[2] cancer registry systems;[3] and vital records systems.[4] These data are useful but because they are limited they cannot be aggregated and analyzed to answer many basic and

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[2] DENISE LOVE & CLAUDIA STEINER, KEY STATE HEALTH CARE DATABASES FOR IMPROVING HEALTH CARE DELIVERY (Feb. 2011), *available at* http://www.apcdcouncil.org/publication/key-state-health-care-databases-improving-health-care-delivery.

[3] *Nat'l Program of Cancer Registries, About the Program*, CENTERS FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/cancer/npcr/about.htm (last visited Aug. 27, 2015).

[4] *Nat'l Vital Statistics Sys., About the Nat'l Vital Statistics Sys.*, CENTERS FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/nchs/nvss/about_nvss.htm (last visited Aug. 27, 2015).

helpful questions that could improve health care quality, access, and cost. Hospital discharge data, for example, are used broadly and in many different ways, including studying patterns of care in the inpatient setting, understanding rates of hospitalization for disease and injury, and exploring patient characteristics for different hospitals. Data all states currently collect can also reveal information about costs for services, which can be used by health care consumers. For instance, certain hospital inpatient data has shown the disparity in costs charged for various procedures in hospitals across the country.[5] To illustrate, data from 2011 showed that one Miami hospital charged $127,038 to implant a pacemaker, while a hospital down the street charged only $66,030. *Id.*

Until recently states have not collected similar data for office-based and other outpatient care ("ambulatory care") except for Medicare[6] and Medicaid patients,[7] although the majority of health care in the United

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[5] Wilson Andrews et al., *Disparity in Medical Billing*, WASHINGTON POST (May 8, 2013), *available at* http://www.washingtonpost.com/wp-srv/special/national/actual-cost-of-medical-care.

[6] Regarding ambulatory care, the Centers for Medicare and Medicaid Services collects and makes available data based on claims paid by Medicare, which includes those 65 and older and those with certain medical conditions. While these data have been used to provide a robust understanding of patterns of care, the data are limited to that population. *Understanding of the Efficiency and Effectiveness of the Health Care System*, THE DARTMOUTH ATLAS OF HEALTH CARE, http://www.dartmouthatlas.org (last visited Aug. 27, 2015).

[7] State-based Medicaid data also provide a wealth of information about the type, quality, and cost of care for that population. But, like Medicare data, Medicaid data reflects only a small, albeit very important, portion of the population, including low-income parents, children and people with disabilities.

States is provided in these settings.[8] For this reason, states have begun implementing health care data collection laws like Vermont's.

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[8] In 2012, 72.4% of the U.S. population had a health care expense related to an office visit. *Office-based Medical Provider Services-Median and Mean Expenses per Person With Expense and Distribution of Expenses by Source of Payment: United States, 2012, All Office-based Medical Provider Services*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, http://meps.ahrq.gov/mepsweb/data_stats/tables_compendia_hh_interactive.jsp?_SERVICE=MEPSSocket0&_PROGRAM=MEPSPGM.TC.SAS&File=HCFY2012&Table=HCFY2012_PLEXP_G&VAR1=AGE&VAR2=SEX&VAR3=RACETH5C&VAR4=INSURCOV&VAR5=POVCAT12&VAR6=MSA&VAR7=REGION&VAR8=HEALTH&VARO1=4+17+44+64&VARO2=1&VARO3=1&VARO4=1&VARO5=1&VARO6=1&VARO7=1&VARO8=1&_Debug (last visited Aug. 27, 2015). The percentage of the population with inpatient hospital, outpatient hospital, or emergency room expense was much lower: 7.5%, 15.8%, and 12.9%, respectively. *Id.* In 2014, only around 20% of the population was covered by public insurance (e.g., Medicare and Medicaid), while approximately 60% were covered by private insurance. *Medical Expenditure Panel Survey Household Component, 2014*, CTR. FOR FIN., ACCESS, AND COST TRENDS, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/hc/hlth_insr/2014/alltables.pdf (last visited Aug. 27, 2015). Further, nearly half of all medical expenses were paid for by private insurance in 2012. *Total Health Services-Median and Mean Expenses per Person with Expense and Distribution of Expenses by Source of Payment: United States 2012*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *available at* http://meps.ahrq.gov/mepsweb/data_stats/tables_compendia_hh_interactive.jsp?_SERVICE=MEPSSocket0&_PROGRAM=MEPSPGM.TC.SAS&File=HCFY2012&Table=HCFY2012_PLEXP_%40&VAR1=AGE&VAR2=SEX&VAR3=RACETH5C&VAR4=INSURCOV&VAR5=POVCAT12&VAR6=MSA&VAR7=REGION&VAR8=HEALTH&VARO1=4+17+44+64&VARO2=1&VARO3=1&VARO4=1&VARO5=1&VARO6=1&VARO7=1&VARO8=1&_Debug (last visited Aug. 27, 2015).

1. Development of State Health Care Data Collection Laws

Recognizing the need for broad-based, health system-wide data to understand key health issues, states began creating All-Payer Claims Databases ("APCDs"), like Vermont's, which hold the potential for a much deeper understanding of patterns, quality, and cost of care across the entire population. In 2007, the Regional All-Payer Healthcare Information Council began as a convening organization to bring together several Northeast states that had, or were developing, APCD systems. The vision was to support cross-state data harmonization and analytic activities. The organization quickly expanded to include states across the country to address a wider variety of activities, such as sharing of processes, addressing common challenges in data acquisition, and identifying resources that could be leveraged across states. In 2010, the organization became the All-Payer Claims Database Council ("APCD Council") to reflect the expanded reach.

As of August 2015, 18 states have enacted legislation creating these health care databases ("state health care data collection laws" or "APCD laws").[9] Currently, there are 14 states with existing APCDs, 4 in implementation, 3 existing voluntary efforts, and at least 5 other

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[9] ARK. CODE ANN. § 23-61-901; COLO. REV. STAT. § 25.5-1-204; CONN. GEN. STAT. § 38a-1091; KAN. STAT. ANN. § 65-6804; ME. REV. STAT. ANN. tit. 22, §§ 8703, 8704; MD. CODE ANN., Health-Gen. § 19-133; MASS. GEN. LAWS ANN. ch. 12C, § 12; MINN. STAT. ANN. § 62U.04; N.H. REV. STAT. ANN. § 420-G:11-a; N.Y. PUB. HEALTH LAW § 2816; OR. REV. STAT. § 442.466; R.I. GEN. LAWS § 23-17.17-10; TENN. CODE ANN. § 56-2-125; UTAH CODE ANN. § 26-33a-106.1; VT. STAT. ANN. tit. 18, § 9410; VA. CODE ANN. § 32.1-276.7:1; WASH. REV. CODE. ANN. 43.371.010; W. VA. CODE § 33-4A-2.

states with interest in developing an APCD.[10] The health care claims-payment data that states collect can be used to analyze health care utilization, cost, quality, and population health, as well as to support health care reform initiatives. Some states also focus on transparency for consumers,[11] to better inform the populace of the true costs of health care services. Two states also use the data to regulate the rates that health insurance companies charge consumers.[12]

In an effort to harmonize state activity around APCDs, the APCD Council has worked with states across the country on a variety of matters related to APCD development, including: coordinating stakeholder meetings; reviewing legislation; assisting with rule

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[10] *Interactive State Report Map*, APCD COUNCIL, http://www.apcdcouncil.org/state/map (last visited Aug. 27, 2015).

[11] *See, e.g.*, CONN. GEN. STAT. § 19a-724(f) (2013).

[12] New Hampshire currently uses the data to regulate rates, while Arkansas recently transferred its data collection efforts to the insurance rate review section, to facilitate their use of the data to regulate insurance rates. Laws like those of New Hampshire and Arkansas may be afforded further protection from preemption under ERISA's savings clause which provides that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking or securities." 29 U.S.C. § 1144(b)(2)(A). To be saved from preemption, a state law must (1) be "specifically directed toward entities engaged in insurance," and (2) "substantially affect the risk pooling arrangement between the insurer and the insured." *Kentucky Ass'n of Health Plans, Inc., v. Miller*, 538 U.S. 329, 342 (2003). If a state's data collection law is used to inform a state's health insurance rate review process or administration of risk adjustment, it would substantially affect the risk pooling arrangement between insurers and insureds because it would dictate the rates that an insurer may charge, and thereby alter the scope of permissible bargains between insurers and insureds.

development; assisting with vendor selection; providing analytics support; linking states to one another to find common solutions; and leveraging state resources to achieve common objectives. Among the APCD Council's efforts is publication of a manual that provides a framework for states to develop their own APCDs.[13] In addition, the APCD Council published model legislation to encourage legal consistency among states.[14]

2. Data are Used for a Variety of Purposes

APCDs are unique administrative datasets that contain information, across all payers, for all ages, in one database, and can supplement the information available through other more limited and restricted data sources. These databases generally include data derived from medical claims, pharmacy claims, eligibility files, provider (physician and facility) files, and dental claims from private and public payers. Given the breadth of APCDs, analysis of these data can answer many important health services research questions for policy makers, consumers, employers, providers, insurers, and researchers. Research and policy questions that can be answered using APCDs include:

- Which providers have the highest prices?
- How far do people travel for services? Which services are they travelling for?
- Which parts of the state have better access to specialists?

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[13] APCD COUNCIL, ALL-PAYER CLAIMS DATABASE DEVELOPMENT MANUAL (Mar. 2015), *available at* https://www.apcdcouncil.org/manual.

[14] APCD COUNCIL, MODEL APCD LEGISLATION (May 2015), *available at* https://www.apcdcouncil.org/publication/model-all-payer-claims-database-legislation.

- Which parts of the state have better access to dental care?
- Are services for mental health, substance use, or primary care available in rural areas?
- What are the drivers of high cost patients and hospital readmissions?
- If emergency room usage in Medicaid is higher than in the commercially-insured population, what are the drivers?
- What are the utilization patterns and rates for Medicaid compared to commercial insurance?
- What are the testing, treatment, and screening trends for communicable diseases? What are the gaps in disease prevention and health promotion services?
- What percentage of the population has had a mammogram?
- What is the average length of time people are using antidepressant medications and what are the patient demographics?

States are developing APCD reporting systems to fill these critical information gaps, to ensure accessibility of data to a broad variety of users, to promote health care transparency initiatives, to improve administrative simplification in the provision of health care services, and to provide actionable information for their stakeholders.[15]

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[15] APCD COUNCIL, ALL-PAYER CLAIMS DATABASE DEVELOPMENT MANUAL (Mar. 2015), *available at* https://www.apcdcouncil.org/manual.

Examples of ways that states have used APCDs are described below.

Pricing Variation: A New Hampshire report released in the fall of 2007 and updated in 2012 uses both APCD data as well as hospital discharge data to look at pricing of inpatient and outpatient services in the state.[16]

Preventive Health Care Services in Medicaid: The New Hampshire Office of Medicaid Business and Policy has published a report comparing the use of preventive health services for those covered by Medicaid versus commercial insurance. The findings of the study highlight opportunities for improvement in the use of preventive services (e.g., cancer screening, asthma medication) in the Medicaid population.[17]

Disseminating Administrative Data: New Hampshire has a web-based reporting and query system, known as HealthWRQS, for the dissemination of data collected systematically by state agencies for public health purposes. It provides community-level information about the burden of cardiovascular disease and mental illness, and the treatment of those conditions.[18]

Burden of Adverse Drug Events: Researchers in Maine and New Hampshire analyzed data from the

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[16] KATHARINE LONDON ET AL., ANALYSIS OF PRICE VARIATIONS IN NEW HAMPSHIRE HOSPITALS (Apr. 2012), *available at* http://www.nh.gov/insurance/lah/documents/umms.pdf.

[17] NEW HAMPSHIRE COMPREHENSIVE HEALTH CARE INFO. SYS., ADULT PREVENTIVE HEALTH CARE IN NEW HAMPSHIRE ISSUE BRIEF – JUNE 2009, *available at* http://www.dhhs.nh.gov/ombp/documents/adultpreventivebrief.pdf (last visited Aug. 27, 2015).

[18] *Healthcare Claims Indicator Report Module*, NH HEALTH WRQS, https://www.nhhealthwrqs.org/HealthWRQS2?SubSystem=CLAIMS (last visited Aug. 27, 2015).

APCDs of those states to determine the scope and costs associated with adverse drug events.[19]

Health Care Delivery Efficiency Improvement: The Minnesota APCD is used to assess the opportunities for greater health care efficiencies.[20]

Spending Trends in Health Care: Massachusetts relies upon the APCD data to develop an annual report examining trends in commercial medical spending including overall spending trends and spending by category of service, type of episode, and region using data from the Massachusetts APCD.[21]

Health Cost Transparency: Price transparency websites that contain comparison prices for a variety of common healthcare procedures allow consumers and employers to identify accessible low cost providers in their area for health care services. Examples include NH HealthCost[22] and Maine HealthCost.[23] Like Maine

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[19] PATRICK MILLER ET AL., ISSUE BRIEF: UTILIZATION AND COSTS FOR ADVERSE DRUG REACTIONS IN MAINE AND NEW HAMPSHIRE: 2005-2007 (2009), *available at* https://chhs.unh.edu/sites/chhs.unh.edu/files/docs/nhihpp/2009_09_03ADEIssueBrief.pdf.

[20] MINN. DEP'T OF HEALTH, AN INTRODUCTORY ANALYSIS OF POTENTIALLY PREVENTABLE HEALTH CARE EVENTS IN MINNESOTA (2015), *available at* http://www.health.state.mn.us/healthreform/allpayer/potentially_preventable_events_072115.pdf.

[21] CTR. FOR HEALTH INFO. AND ANALYSIS & HEALTH POLICY COMM'N, MASSACHUSETTS COMMERCIAL MEDICAL CARE SPENDING: FINDINGS FROM THE ALL-PAYER CLAIMS DATABASE 2010-2012 MEDICAL CLAIMS PAYMENTS FOR THE THREE LARGEST COMMERCIAL PAYERS (July 2014), *available at* https://www.mass.gov/anf/docs/hpc/apcd-almanac-chartbook.pdf.

[22] NH HEALTHCOST, https://www.nhhealthcost.org (last visited Aug. 27, 2015).

[23] MAINE HEALTHCOST, https://mhdo.maine.gov/healthcost2014/CostCompare (last visited Aug. 27, 2015).

and New Hampshire, several states cater directly to health care consumers.[24] And consumers are experiencing direct benefits from cost transparency. For example, when a six-year-old girl cut her eyebrow and needed stitches, the girl's mother was able to compare emergency room costs for that procedure on the NH HealthCost website. *Id.* She used the data to save $500 by driving to a hospital 20 minutes further than the one closest to her home. *Id.* Insurers are using the health care cost data too. The largest health insurer in New Hampshire was able to renegotiate a hospital contract after discovering that the hospital was charging rates that were 50% higher than other hospitals.[25]

3. Data Collection and Reporting is Standardized and Routine

States have developed APCDs by leveraging existing data systems in place for the claims adjudication processes, i.e., the processes by which claims are submitted to and paid by health insurers. State-based claims data systems collect data from the commercial carriers' data storage systems. Providers of care and payers exchange data on these systems for the purposes of adjudication. The state APCDs collect data elements that are typically part of the adjudication process for both private and public payers, such as Centers for Medicare and Medicaid Services (CMS).

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[24] Elizabeth Cohen, *How to Save Money on Health Care*, CNN, (Mar. 4, 2010), *available at* https://www.cnn.com/2010/HEALTH/03/04/medical.waste/.

[25] Beth Kuscher, *How New Hampshire Took the Guesswork Out of Healthcare Costs*, MODERN HEALTHCARE (July 16, 2015), *available at* http://www.modernhealthcare.com/article/20150716/NEWS/150719922.

Therefore, the collected data already exists and is readily accessible in the payer's system.

Because claims data are generated for billing purposes, the data elements are generally available across payer systems. Uniformity of data submission is important, both for reasons of comparability within and across states and to reduce the payers' burden to submit data to different states in different formats. To address these issues there are initiatives to standardize data reporting formats.[26] In fact, "[i]n 2010 and 2011, the APCD Council convened a Technical Advisory Panel to build consensus around the APCD data collection standardization process." *Id.* Several large health insurers participated on the panel including Aetna, Cigna, Humana, and Kaiser Permanente. *Id.* Early efforts in standardization have resulted in industry reporting standards that align with both state reporting needs and payer reporting capabilities. *Id.*

4. Data Completeness is Important

States have developed APCDs to answer important public health, public policy and health care market questions. The most accurate understanding of the population in a state comes from analyzing comparable data collected from the majority of the population. Therefore, availability of data from both the insured and self-insured population is critically important to states for health care planning, public policy and economic development.

In this case, Liberty Mutual seeks to avoid participation in this important data collection simply because it is a self-insured plan. If APCD laws are found to be preempted by ERISA, an employers' choice to self-

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[26] *Standards*, APCD COUNCIL, https://www.apcdcouncil.org/standards (last visited Aug. 27, 2015).

insure its workforce would result in a permanent lack of critical claims data necessary for the improvement of the health care system. The exclusion of data from self-insured plans is not insignificant. The number of participants in self-insured plans governed by ERISA has been increasing over the last several years. As of 2012, that number reached 69.8 million.[27]

B. The Presumption Against Preemption Applies

"[T]he regulation of health and safety matters is primarily, and historically, a matter of local concern." *Hillsborough County, Fla. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 719 (1985). Liberty Mutual must "bear the considerable burden of overcoming 'the starting presumption that Congress does not intend to supplant state law.'" *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806, 814 (1997) (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654 (1995)).

As an initial matter, the state data collection does not encroach on ERISA's objectives. *California Div. of Labor Standards Enforcement v. Dillingham Const., N.A., Inc.*, 519 U.S. 316, 325 (1997). The Second Circuit majority opinion mistakenly declares "reporting" to be a core ERISA function, *Donegan*, 746 F.3d at 508, without analyzing the distinction between the type of information required by the Department of Labor and that required by the state laws, and in direct contravention of the Department of Labor's position. Brief

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[27] CONSTANTIJN PANIS & MICHAEL BRIEN, SELF-INSURED HEALTH BENEFIT PLANS 2015 BASED ON FILINGS THROUGH STATISTICAL YEAR 2012 (2014), *available at* http://www.dol.gov/ebsa/pdf/ACASelfFundedHealthPlansReport2015.pdf.

for Acting Secretary of the United States Department of Labor as Amicus Curiae Supporting Defendant-Appellee (Gobeille) at 12-14, *Donegan*, 746 F.3d 497 (2d Cir. 2014) (No. 12-4881) [hereinafter DOL Second Circuit Amicus Brief]. The core functions of the ERISA statute are "determining the eligibility of claimants, calculating benefit levels, making disbursements, [and] monitoring the availability of funds for benefit payments." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). While plans are required to furnish reports, 29 U.S.C. §§ 1021-30, those reports relate to the provision of benefits to participants and the financial soundness of the plans (e.g., "monitoring the availability of funds for benefit payments").

As the Department of Labor made clear, it does not collect the data sought by the states, and there is no overlap between the reporting requirements of the federal and state governments. DOL Second Circuit Amicus Brief at 13 (the Vermont law "does not impose conflicting data collection or reporting requirements . . . and does not appreciably add to the burdens of complying with ERISA reporting requirements or serve the same purpose as ERISA's reporting regime").

The Second Circuit also found that the state laws are burdensome (albeit without any record support). *Donegan*, 746 F.3d at 509, 515. Liberty Mutual never presented evidence that complying with the law constituted a burden. In fact, its third-party administrator, which maintained the data, was by all accounts "happy to provide the data Vermont has asked for, and it does so for other clients." *Id.* at 515 (J. Straub, dissenting in part and concurring in part).

The APCD laws are not burdensome. They do not require any recordkeeping, and only require plans (along with all other health care payers) to report information

already in their possession. And while a multiplicity of reporting regimes theoretically could impact plans so adversely as to alter their benefit structure, states are working together, through the APCD Council and other entities, to minimize such burdens. For instance, a model law promotes uniformity for states enacting their own legislation. MODEL APCD LEGISLATION, *supra* note 14. And states have used existing claims adjudication processes as the basis for the reporting requirements, thereby limiting the impact of the administrative burden of compliance. *Standards*, *supra* note 26.

As a result, the presumption against preemption is not overcome, since the states' reporting laws are laws of general applicability with only incidental impact on ERISA plans. *Travelers*, 514 U.S. at 661.

II. State Health Care Data Collection Laws Do Not "Relate To" ERISA Plans

In recognition of the strong presumption against preemption, 20 years ago, this Court rejected its previously broad reading of ERISA's preemption clause. *Travelers*, 514 U.S. at 655 (1995). That clause, Section 514(a) of ERISA, 29 U.S.C. § 1144(a), preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. The Travelers Court explained that the words of limitation ("insofar as they . . . relate") would effectively be limitless "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy[.]" *Travelers*, 514 U.S. at 655. If so, "preemption would never run its course, for 'really, universally, relations stop nowhere[.]" *Id.* (quoting H. James, Roderick Hudson xli (New York ed., World's Classics 1980)). This Court acknowledged that its "prior attempt[s] to construe the phrase 'relate to' d[id] not give [] much help drawing the line." *Id.*

at 655. Ultimately, *Travelers* stands for the "rejection of a strictly literal reading of § 514(a)." *DeBuono*, 520 U.S. at 813.

The New York statutes at issue in *Travelers* required hospitals to collect surcharges from patients covered by a commercial insurer but not from those insured by a nonprofit Blue Cross/Blue Shield plan. *Travelers*, 514 U.S. at 649. They also subjected certain health maintenance organizations to surcharges based on the number of Medicaid recipients they enrolled. *Id.* This Court determined that these laws did not "relate to" ERISA because they "affect only indirectly the relative prices of insurance policies, a result no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate." *Id.* at 668.

Even prior to *Travelers*, only two categories of state laws were found to be "related to," and, thus, preempted by, ERISA: "those that mandate employee benefit structures or their administration . . . and those providing alternative enforcement mechanisms." *Id.* at 657-8 (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983); *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 141 (1990)).

In *Shaw*, for example, the preempted state statutes "'relate[d] to' benefit plans" by "prohibit[ing] employers from structuring their employee benefit plans in a manner that discriminate[d] on the basis of pregnancy" and by "requir[ing] employers to pay employees specific benefits." *Travelers*, 514 U.S. at 657 (quoting *Shaw*, 463 U.S. at 97, 103). Likewise, a Pennsylvania antisubrogation law was found to be related to employee benefit plans because it "prohibited 'plans

from . . requiring reimbursement [from the beneficiary] in the event of recovery from a third party.'" *Id.* (quoting *Holliday*, 498 U.S. at 60). This resulted in some Pennsylvania employees recovering benefits in excess of what employees in other states received and prevented plan administrators from calculating "uniform benefit levels nationwide." *Id.* Similarly, a New Jersey law was found to be related to ERISA plans because it "prohibit[ed] plans from setting workers' compensation payments off against employees' retirement benefits or pensions because doing so would prevent plans from using a method of calculating benefits permitted by federal law." *Id.* (citing *Alessi*, 451 U.S. at 524).

The APCD laws at issue here do not implicate any of the concerns in the cases cited above. The APCD laws do not mandate employee benefit structures nor do they provide alternative enforcement mechanisms. They do not impose any conditions that would affect the contractual relationship among the involved parties. And their relationship to ERISA is even more indirect than the surcharges at issue in *Travelers* because APCD laws do not impose fees or taxes but simply seek already-existing information from *all* health care payers.

In deciding *Travelers*, this Court referred back to a pronouncement made more than 10 years previously, that a law "relates to" an employee benefit plan "if it has a connection with or reference to such a plan." *Id.* at 656 (quoting *Shaw*, 463 U.S. at 96-97).[28] Determining

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[28] The issue of whether the Vermont law makes "reference to" ERISA is not before this Court. Liberty Mutual did not raise this point in its Memorandum in Support of its Motion for Summary Judgment in the district court or in its brief filed with the Second Circuit.

whether a law has a "connection with" ERISA plans can result in the same frustration as determining whether a law is "related to" ERISA plans since "infinite connections," like "infinite relations cannot be the measure of pre-emption." *Id.* at 656. Therefore, we look to "'the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive . . . as well as to the nature of the effect of the state law on ERISA plans.'" *Dillingham*, 519 U.S. at 325 (quoting *Travelers* at 658-59). This analysis is done under the "'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.'" *Id.* In pursuing this line of inquiry, it is clear that the state APCD laws have no "connection with" ERISA plans.

A. Congress Did Not Intend ERISA to Supersede State Health Care Data Collection Laws

The Second Circuit Court of Appeals incorrectly seized on the fact that the federal law imposes "reporting" requirements on plan providers. *Donegan*, 746 F.3d at 508. But this "misses the nuance of what 'reporting'

A law contains an impermissible "reference to" ERISA plans, where it "acts immediately and exclusively upon ERISA plans . . or where the existence of ERISA plans is essential to the law's operation. *Dillingham*, 519 U.S. at 325 (citations omitted). The Vermont law and the other APCD laws apply generally to all providers, purchasers and insurers, including self-insured plans governed by ERISA. It cannot be said that these statutes contain a "reference to" ERISA plans. As laws applicable to "all payers," they do not "act[] immediately and exclusively upon ERISA plans." *Id.* at 325 (citations omitted). As laws of general application, "the existence of ERISA plans" is not "essential to the law[s'] operation." *Id.*

means in the context of ERISA." *Id.* at 511 (J. Straub, dissenting in part and concurring in part). ERISA plan administrators are required to provide a summary plan description to participants and to file an annual report with the Department of Labor. *See* 29 U.S.C. §§ 1021-1030. The summary plan description notifies participants of their rights and obligations under the plan, while the annual report seeks financial and actuarial information from the plan. *See id.* Among the purposes of these reports is to ensure that the plan is "operated according to instructions and in the best interests of participants and beneficiaries" and to enable participants "to know whether the plan [is] financially sound and being administered as intended." S. REP. NO. 93-127, 93th Cong., 2nd Sess. 1974, 1974 U.S.C.C.A.N. 4838, 4863.

While the Department of Labor is authorized "to undertake research and surveys and . . . to collect, compile, analyze and publish data, information, and statistics relating to employee benefit plans," 29 U.S.C. § 1143, the Department of Labor has stated that it does not collect any of the data states are collecting under these laws. DOL Second Circuit Amicus Brief at 12. In fact, Congress' primary concern, in enacting ERISA, "was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds." *Dillingham*, 519 U.S. at 326-27; *Massachusetts v. Morash*, 490 U.S. 107, 115, 109 (1989). Based on this concern, Congress "established extensive reporting, disclosure, and fiduciary duty requirements to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator." *Morash*, 490 U.S. at 115.

Thus, the "reporting" mandated by Congress is of an entirely different nature and scope from the "reporting" required by the states. Congress is concerned with the solvency and viability of ERISA plans to ensure that participants and beneficiaries are guaranteed their benefits. States, on the other hand, are concerned with the nature, cost, and quality of health care services among *all* health care providers and carriers, which just happens to include ERISA plans among a number of other affected entities. There is no indication, in the law or legislative history that in enacting ERISA, Congress had the "clear and manifest purpose" of superseding the "historic police powers of the States" with regard to health care policy. *See Dillingham*, 519 U.S. at 325. "[N]othing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S.at 661 (citations omitted).

Of particular assistance in understanding ERISA's history is the fact that, just months after adopting ERISA, the same Congress adopted the National Health Planning and Resources Development Act of 1974 (NHPRDA). Pub. L. 93-641, 88 Stat. 2225, §§ 1-3, repealed by Pub. L. 99-660, title VII, § 701(a), 100 Stat. 3799. "The NHPRDA sought to encourage and help fund state responses to growing health care costs and the widely diverging availability of health services." *Travelers*, 514 U.S. at 665 (citations omitted). The NHPRDA "provided for the organization and partial funding of regional 'health systems agencies' responsible for gathering data as well as for planning and developing health resources in designated health service areas." *Id.* In acknowledging the historic police powers of states in matters of health care policy, Congress asked the states to "gather data" in order to respond

to "growing health care costs." *Id.* This is precisely what states are currently doing with the APCD laws at issue here. Indeed, among the goals of the NHPRDA was establishing state agencies to "regulat[e] rates for the provision of health care." *Id.* at 666. Most states with health care databases are not even taking the extra step of "regulating rates" and are simply providing information to consumers, providers and others in an effort to promote efficiency, efficacy and transparency in the provision of health care services.

The *Travelers* Court compared the purposes and goals of the NHPRDA with New York's hospital surcharge laws, finding that "the statute[s'] provision for comprehensive aid to state health care rate regulation is simply incompatible with pre-emption of the same by ERISA." *Id.* at 667. Likewise, in comparing the purposes and goals of the NHPRDA with the state APCD laws, there can be no finding that Congress had any intention of preempting such laws.

B. State Health Care Data Collection Laws Do Not Interfere or Conflict with ERISA

In applying ERISA preemption, the Second Circuit focused on the fact that different states may collect different data leading to a lack of "national uniformity" in data collection that would be burdensome to self-insured plans. The Second Circuit explained that "[p]reemption 'was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law . . to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government." *Donegan*, 746 F.3d at 504-05 (citations omitted). But uniformity in health care data reporting

is not the type of uniformity that ERISA is concerned with.

The statutes that have been found to interfere with national uniformity include those that "mandated employee benefit structures or their administration." *Travelers*, 514 U.S. at 658. These preempted statutes have included the following: a law that prohibited "a method of calculating pension benefits that federal law permit[ted]"; a law that "required employers to provide certain benefits"; an antisubrogation law that "require[d] plan providers to calculate benefit levels . . based on expected liability conditions that differ[ed] from those" in other states; and a law that prevented administrators from "mak[ing] payments simply by identifying the beneficiary specified by the plan documents" and, instead required them to "familiarize themselves with state statutes so that they c[ould] determine whether the named beneficiary's status has been 'revoked' by operation of law." *DeBuono*, 520 U.S. at 814-15 (citing *Alessi*, 451 U.S. at 524-25; *Shaw*, 463 U.S. 85; *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985)); *Travelers*, 514 U.S. at 657-58 (quoting *Holliday*, 498 U.S. at 60); *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 142 (2001). These are the types of laws that "frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide." *Holliday*, 498 U.S. at 60.

The state APCD laws at issue here have no impact whatsoever on an ERISA plan's calculation of benefit levels. Furthermore, states enacting these laws are seeking uniformity for reasons that have nothing to do with ERISA. It is to the states' advantage that they collect data in a similar manner so that eventually, the data can be compared with other states. The work of the APCD Council, including the issuance of its model

law, helps ensure that these laws are harmonized across the country. So, while states might request submission of different data fields from the *already existing* claims data held by plan administrators, this hardly rises to the level of conflict ERISA preemption seeks to avoid. Additionally, payers, providers and other data submitters have the opportunity to participate in the legislative process, to ensure that the burdens across borders are minimized.

Nor would the incidental costs involved with providing the data require preemption of the state APCD laws. "Any state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute." *DeBuono*, 520 U.S. at 816. As the *Travelers* Court explained, "cost uniformity was almost certainly not an object of pre-emption, just as laws with only an indirect economic effect on the relative costs of various health insurance packages in a given State are a far cry from those 'conflicting directives' from which Congress meant to insulate ERISA plans." *Travelers*, 514 U.S. at 662. "Pre-emption does not occur . . . if the state law has only a tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability." *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 130 n.1 (1992) (citations omitted). The state APCD laws, which are laws of general applicability have only a "tenuous, remote, or peripheral connection with covered plans" and, therefore, cannot be found to be preempted.

CONCLUSION

For these reasons, the judgment of the Second Circuit should be reversed.

Respectfully submitted,

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No. 14-181

IN THE

Supreme Court of the United States

ALFRED GOBEILLE, in His Official Capacity as Chair of the Vermont Green Mountain Care Board,

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

ON WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS FOR
THE SECOND CIRCUIT

BRIEF OF AMICUS CURIAE NEW ENGLAND LEGAL FOUNDATION IN SUPPORT OF RESPONDENT

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October 20, 2015

BATEMAN & SLADE, INC. BOSTON, MASSACHUSETTS

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INTEREST OF AMICUS CURIAE [1]

New England Legal Foundation ("NELF") is a nonprofit, nonpartisan, public-interest law firm incorporated in Massachusetts in 1977 and headquartered in Boston. Its membership consists of corporations, law firms, individuals, and others who believe in NELF's mission of promoting balanced economic growth in New England and the nation as a whole, protecting the free-enterprise system, and defending individual economic rights and the rights of private property. NELF's members and supporters include both large and small businesses located primarily in New England. NELF has filed numerous amicus briefs in this Court in cases that raise concerns to NELF's members and supporters, including those in the business community. The outcome of some of those cases has turned, as this one does, on the interpretation of a federal statute.[2]

NELF believes that free enterprise, as well as the national economy generally, suffers when States impose on businesses additional regulation that

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[1] Pursuant to Supreme Court Rule 37.6, Amicus states that no party or counsel for a party authored this brief in whole or in part and that no person or entity, other than Amicus, made a monetary contribution to the preparation or submission of the brief.

Pursuant to Supreme Court Rule 37.3(a), Amicus also states that on July 9 counsel for the Petitioner filed with this Court a written consent to the filing of amicus briefs in support of either or neither party, and that on July 10 counsel for the Respondent filed with this Court a similar consent.

[2] *See*, e.g., *Kellogg Brown & Root Serv., Inc. v. U.S. ex rel. Carter*, 135 S. Ct. 1970 (2015); *Lawson v. FMR LLC*, 134 S. Ct. 1158 (2014).

frustrates the objectives or operation of federal law. The Supremacy Clause serves a key structural role in our form of government because the doctrine of preemption it enshrines in the Constitution protects federal law from such encroachment and interference by State and lower levels of government. In the realm of commerce, for example, by ensuring that federal regulation cannot be undermined or subverted by State or local law, it enables Congress to create uniform national markets. For these reasons, NELF files this amicus brief in order to address whether the Court, in attempting to discern congressional intent in an express preemption provision, ought to employ a presumption that Congress does not intend to preempt State laws that regulate areas of traditional State concern.

SUMMARY OF THE ARGUMENT

The presumption against preemption and in favor of the States' prerogative to legislate in so-called areas of traditional State regulation is a late-adopted principle of this Court and one applied fitfully.

When Congress has included an express preemption provision in a statute, that provision obviates any need for the presumption because the text itself clearly establishes the *fact* of preemption. The actual language, purpose, and context of the statute provide better evidence of the scope of the intended preemption than could be given by any non-textual presumption.

When an express preemption provision is present, use of the presumption risks overriding the level of deference to State interests (if any) embodied

in the words of the statute enacted by Congress, and it may bestow a kind of undue, double weight on considerations of federalism. It also creates the further analytical problem of how to delimit the supposed area of traditional State concern.

ARGUMENT

THE PRESUMPTION AGAINST PREEMPTION SHOULD NOT BE APPLIED WHEN THERE EXISTS AN EXPRESS PREEMPTION PROVISION.

Preemption traces its constitutional source primarily to article VI, cl. 2 of the U.S. Constitution:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof . . . shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

As Justice Story observed of the Supremacy Clause, "surely a positive affirmance of that, which is necessarily implied, cannot in a case of such vital importance, be deemed unimportant." 3 *Commentaries on the Constitution of the United States* 693 (Boston, Hilliard, Gray & Co.; Cambridge, Brown, Shattuck & Co. 1833).

This Court's earliest cases dealing with Supremacy Clause preemption were decided without recourse to, or even mention of, a presumption against the preemption of State laws regulating

areas of traditional State concern.[3] *See, e.g., Martin v. Hunter's Lessee*, 14 U.S. (1 Wheat.) 304 (1816); *Ware v. Hylton*, 3 U.S. (3 Dall.) 199 (1796). On the contrary, in those cases the Court recognized that "the acts of the State Legislatures . . . though enacted in the execution of acknowledged State powers, . . . though enacted in the exercise of powers not controverted, must yield to [the acts of Congress]." *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 82 (1824).

It has been long acknowledged by this Court that whether Congress has preempted the exercise of State lawmaking over a given subject matter is a question of the congressional intent. The Court has repeatedly emphasized that "[p]re-emption fundamentally is a question of congressional intent and when Congress has made its intent known through explicit statutory language, the courts' task is an easy one." *English v. General Electric Co.*, 496 U.S. 72, 78-79 (1990) (citations omitted). *See also Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 516 (1992) ("'purpose of Congress is the ultimate touchstone' of preemption analysis") (quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978)); *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 486 (1996) ("any understanding of the scope of a preemption statute must rest primarily on 'a fair understanding of *congressional purpose*'") (original emphasis)

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[3] Indeed, some commentators have even claimed that one might arguably find a textual basis in the Supremacy Clause for a presumption in *favor* of preemption. *See* Caleb Nelson, *Preemption*, 86 Va. L. Rev. 225, 255 (2000); Viet D. Dinh, *Reassessing the Law of Preemption*, 88 Geo. L.J. 2085, 2093 (2000).

(quoting *Cipollone*, 505 U.S. at 530 n.27 (opinion of Stevens, J.)).

And, in order "[t]o discern Congress' intent," the Court has frequently stated, "we examine the explicit statutory language and the structure and purpose of the statute." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990).

Justice Scalia has observed on this point, "Under the Supremacy Clause, our job is to interpret Congress's decrees of pre-emption neither narrowly nor broadly, but in accordance with their apparent meaning." *Cipollone*, 505 U.S. at 544 (concurring in the judgment in part and dissenting in part) (citation omitted).

However, in 1947 this Court added to its interpretive tools the working "assumption" that the "historic police powers of the States" should not be deemed to be superseded when "Congress legislate[s] . . . in [a] field which the States have traditionally occupied" unless to do so was "the clear and manifest purpose of Congress." *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947).

While the presumption formulated in *Rice* may have been adopted by the Court in order to assist it in discerning Congress's intention, there has been no shortage of scholars who, however much they may disagree among themselves on other legal points, agree that the Court has signally failed to employ the presumption in a consistent methodological fashion. *See, e.g.*, Thomas W. Merrill, *Preemption and Institutional Choice*, 102 Nw. U. L. Rev. 727, 741 (2008) ("[T]he presumption against preemption is honored as much in the breach as in observance."); Mark D. Rosen, *Contextualizing Preemption*, 102 Nw. U. L. Rev. 781, 785 (2008)

(presumption "is only inconsistently invoked and applied"); S. Candice Hoke, *Preemption Pathologies and Civic Republican Values*, 71 B.U. L. Rev. 685, 733 (1991); Nelson, *supra*, at 288-89; Catherine M. Sharkey, *Products Liability Preemption: An Institutional Approach*, 76 Geo. Wash. L. Rev. 449, 458 (2008) ("haphazard application of the presumption"); Ernest A. Young, *"The Ordinary Diet of the Law": The Presumption Against Preemption in the Roberts Court*, 2011 Sup. Ct. Rev. 253, 307 ("The Justices ignored *Rice* in *Williamson* and *Concepcion* and invoked it only in dissent in *PLIVA* and *Bruesewitz*.").

In any event, the presumption is of dubious utility in cases that, like the present one, deal with an express preemption provision. When Congress has included an express preemption provision in a statute, the provision banishes any need for the presumption because it clearly states the *fact* of preemption. *See Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 151 (2001) (presumption against pre-emption in areas of traditional state regulation is "overcome where . . . Congress has made clear its desire for pre-emption"). From that point on, the language, purpose, and context of the statute provide much surer guidance to Congress's intended meaning than could be given by any further use of a presumption unmoored to the statutory text. Indeed, if the goal truly is to discern congressional intent, the presumption may be a treacherous guide leading one *into* the wilderness, not out of it. *See* Nelson, *supra,* at 292 ("If the Court's normal rules of statutory interpretation are designed to give effect to congressional intent, then the Court's insistence on giving express preemption clauses a narrower-than-

usual interpretation will drive preemption decisions away from that intent.").

Addressing the "oft-repeated assumption that, absent convincing evidence of statutory intent to pre-empt, the historic police powers of the States [are] not to be superseded," Justice Scalia has written that "it seems to me that assumption dissolves once there is conclusive evidence of intent to pre-empt in the express words of the statute itself, and the only remaining question is what the *scope* of that pre-emption is meant to be." *Cipollone*, 505 U.S. at 545 (concurring in the judgment in part and dissenting in part) (internal quotation marks and further citation omitted; original emphasis). He went on to observe:

> The proper rule of construction for express pre-emption provisions is, it seems to me, the one that is customary for statutory provisions in general: Their language should be given its ordinary meaning. . . . When this suggests that the pre-emption provision was intended to sweep broadly, our construction must sweep broadly as well. . . . And when it bespeaks a narrow scope of pre-emption, so must our judgment.

Id. at 548. *See also* Dinh, *supra*, at 2100 ("The work of the Court is likewise limited and rather straightforward: to interpret the express preemption clause and determine whether the state law at issue falls within the preemptive scope. This is neither constitutional law nor Supremacy Clause jurisprudence; it is statutory construction, plain and simple."); Nelson, *supra*, at 302 ("Congress's chosen level of deference to state interests will be reflected

in the *language* that Congress enacts, and there is no reason automatically to give that language a narrowing construction.") (emphasis added). *But see Altria Group, Inc. v. Good*, 555 U.S. 70, 76-77 (2008); *Lohr*, 518 U.S. at 485.

In his book on statutory interpretation, Justice Scalia returned to this point as part of his treatment of the subject of preemption:

> While any determination about field preemption is highly fact-bound, two principles seem to us clearly required. First, the preemption canon ought not to be applied to the text of an explicit preemption provision. That is, the text ought to be given its fair meaning rather than a meaning narrowed by the presumption. The reason is obvious: The presumption is based on an assumption of what Congress, in our federal system, would or should normally desire. But when Congress has explicitly set forth its desire, there is no justification for not taking Congress at its word—i.e., giving its words their ordinary, fair meaning.

Antonin Scalia and Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts* 293 (2012).

Employing this approach in *Wisconsin Dep't of Revenue v. William Wrigley, Jr., Co.*, this Court wrote, "Because [the federal statute] unquestionably *does* limit the power of States to tax companies whose only in-state activity is 'the solicitation of orders,' our task is simply to ascertain the fair meaning of that [statutory] term."). 505 U.S. 214, 224 (1992) (original emphasis).

Justice Kennedy wrote in a similar vein, in his partial concurrence in *Gade v. Nat'l Solid Wastes Mgmt. Ass'n*:

> I believe, however, that this result [preemption] is mandated by the express terms of § 18(b) of the OSH Act. It follows from this that the pre-emptive scope of the Act is also limited to the language of the statute. When the existence of pre-emption is evident from the statutory text, our inquiry must begin and end with the statutory framework itself.

505 U.S. 88, 111 (1992) (concurring in part and concurring in the judgment). *See also id.* at 112 ("We have held, in express pre-emption cases, that Congress' intent must be divined from the language, structure, and purposes of the statute as a whole.").

The use of the presumption is problematic in other regards as well. This Court has observed that, under the Supremacy Clause, "[t]he relative importance to the State of its own law is not material when there is a conflict with a valid federal law, for any state law, however clearly within a State's acknowledged power, which interferes with or is contrary to federal law, must yield." *Felder v. Casey*, 487 U.S. 131, 138 (1988) (internal quotation marks and further citation omitted). Indeed, "even state regulation designed to protect vital state interests must give way to paramount federal legislation." *DeCanas v. Bica*, 424 U.S. 351, 357 (1976).

As recently as 2008, this Court, in words especially relevant to the issue in this case, explained why a federal law preempted a Maine

public health law regulating the transportation of cigarettes:

> Despite the importance of the public health objective [of the Maine law], we cannot agree with Maine that the federal law creates an exception on that basis, exempting state laws that it would otherwise pre-empt. The [federal] Act says nothing about a public health exception. To the contrary, it explicitly lists a set of exceptions (governing motor vehicle safety, certain local route controls, and the like), but the list says nothing about public health.

Rowe v. New Hampshire Motor Transp. Ass'n, 552 U.S. 364, 374 (2008). This Court has previously noted that ERISA too is an example of federal law preempting an entire field traditionally regulated by the states. *See Alessi v. Raybestos, Inc.*, 451 U.S. 504, 510, 523 (1981) (ERISA "comprehensive and reticulated statute" explicitly establishing "pension plan regulation as exclusively federal concern") (internal quotation marks and further citation omitted). And, as with the statute examined in *Rowe*, the express exceptions to preemption listed in ERISA say "nothing about public health." *See* 29 U.S.C. § 1144(b).

Use of the presumption is also troubled by the problem of deciding how narrowly or expansively to define the relevant field of supposed traditional State regulation. *See* Young, *supra*, at 336. *Cf. Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 546-47 (1985) ("We therefore now reject, as unsound in principle and unworkable in practice, a rule of state immunity from federal regulation that

turns on a judicial appraisal of whether a particular [State] governmental function is 'integral' or 'traditional.'"). The present case exemplifies this problem, with the two sides contending over whether the relevant field should be viewed broadly, with the emphasis falling on traditional State health and welfare concerns, or narrowly, with the focus falling on the novelty of the intrusive means by which data is to be collected for the State under the Vermont law. This disagreement was mirrored in the sharply differing views taken by the majority opinion and the dissent in the appeals court. *See Liberty Mutual Ins. Co. v. Donegan*, 746 F.3d 497, 506 n.8 (2014); *id.* at 512-13 (Straub, J. dissenting).

Finally, because the judicially fashioned presumption against preemption necessarily works to narrow interpretation, it gives the "safeguards of federalism a kind of double weight" beyond the weighting intended by Congress as manifested in the statutory text enacted by that body.

> Once Congress has decided upon the proposal that it will enact, however, the political safeguards of federalism have done their work. For courts always to adopt narrowing constructions of the language that Congress enacts would be to give the political safeguards of federalism a kind of double weight

Nelson, *supra*, at 300. *Cf. South Carolina v. Baker*, 485 U.S. 505, 512 (1988) ("States must find their protection from congressional regulation through the national political process, not through judicially defined spheres of unregulable state activity").

When the Court "systematically favor[s] one result over another" by applying a presumption

against preemption, it "risk[s] an illegitimate expansion of the judicial function" by "disrupt[ing] the constitutional division of power between federal and state governments, rewrit[ing] the laws enacted by Congress, or both." Dinh, *supra*, at 2092. *See also Cipollone*, 505 U.S. at 544 ("our job is to interpret Congress's decrees of pre-emption neither narrowly nor broadly, but in accordance with their apparent meaning") (Scalia, J. concurring in the judgment in part and dissenting in part) (citation omitted).

CONCLUSION

For the reasons stated above, the Court should not adopt the presumption against preemption in this case when determining the scope of the express preemption provision found in ERISA.

Respectfully submitted,

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No. 14-181

In The Supreme Court of the United States

ALFRED J. GOBEILLE, IN HIS OFFICIAL CAPACITY AS CHAIR OF THE VERMONT GREEN MOUNTAIN CARE BOARD,

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

BRIEF AMICUS CURIAE OF THE STATE OF NEW HAMPSHIRE IN SUPPORT OF PETITIONER

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NEW HAMPSHIRE'S INTEREST AS AMICUS CURIAE[1]

New Hampshire was the first state to use price transparency and market forces to foster competition and consumer choice in its health insurance markets through its comprehensive health claims database and website, both of which were created as an integral part of the state's system of insurance regulation. These efforts, which have helped to rein in health cost growth in New Hampshire, would be thwarted were this Court to affirm the ruling by the Second Circuit Court of Appeals that Vermont's health claims data reporting law, Vt. Stat. Ann. tit. 18, § 9410, is preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. Chapter 18 ("ERISA").[2] New Hampshire submits this brief to support Vermont's position that its law is not preempted, and to bring to the Court's attention the serious implications of this case for states' continued ability to serve as the primary regulators of their health insurance markets.

In 2007, the New Hampshire Insurance Department ("NHID") launched NH HealthCost,[3] a

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[1] New Hampshire submits this brief pursuant to Supreme Court Rule 37.4.

[2] *Liberty Mut. Ins. Co. v. Donegan*, 746 F.3d 497 (2d Cir. 2014).

[3] http://nhhealthcost.nh.gov/ As noted on the site's home page, NH HealthCost was developed by the NHID to improve the price transparency of health care services in New Hampshire. Through NH HealthCost, New Hampshire residents can compare prices from health care providers throughout the state

(Continued on following page)

consumer-friendly website that makes information derived from the state's all-payer claims database directly accessible to all members of the public – not only to researchers, legislators and health industry players, but also to consumers and employers, the individuals and organizations that purchase and use health insurance and health care services.[4] NH HealthCost users can easily compare the cost of having a medical procedure performed by different medical providers within the state, understand what their cost-sharing obligation would be for the procedure, and see what different insurance carriers have paid to different providers to perform the procedure. Making claims data public has helped consumers, who in New Hampshire as in the rest of the country face an increasing burden of cost-sharing in today's

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on more than two dozen medical procedures, including MRIs, CT scans, ultrasounds, and X-rays. The information on the site is derived from claims data collected from New Hampshire's health insurers and stored as a part of the Comprehensive Health Care Information System (NHCHIS). Data on the NH HealthCost website is updated quarterly.

[4] In 2015, New Hampshire was the only state to receive an "A" for Price Transparency from the Health Care Incentives Improvement Institute, which found that the NH HealthCost site is "a prime example of a price transparency website built with consumers in mind. The site accounts for both insured and uninsured patients and provides great details on the methodology in consumer-friendly terms." 2015 Report Card on State Price Transparency Laws, July 2015 at 1, Health Care Incentives Improvement Institute, http://www.hci3.org/sites/default/files/files/2015_Report_PriceTransLaws_06.pdf.

health insurance markets and are expected to act as prudent purchasers of health care services.[5]

The availability of data through NH HealthCost has also fostered competition in New Hampshire's markets. Use of the site enables insurance carriers to better understand the market price for health care services, encouraging competition including the development of health plan designs that create incentives for using lower-cost providers.[6] The transparency created by the NH HealthCost website has given New Hampshire employers, including those operating health plans governed by ERISA, access to statistics on market characteristics and the market shares of

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[5] The NHID's most recent comprehensive report on health insurance markets found that between 2012 and 2013, "average deductibles grew $148 or by 10% overall. Over the same time period, the average for non-zero deductibles grew 8% overall." *Supplemental Report of the 2013 Health Insurance Market in New Hampshire*, January 14, 2015 ("2013 NH Market Report") at 17, http://www.nh.gov/insurance/lah/documents/2013_nhid_suprpt.pdf.

[6] A recent article described how New Hampshire's experience "suggests that publishing payment rates can have an impact on negotiations between insurers and providers," and noted that the initiative "also has encouraged new health plan benefit designs that are sending consumers to lower-cost care settings, and prompted hospitals to offer patients lower-cost care settings." Kutscher, Beth, "How New Hampshire Took the Guesswork Out of Health Costs," Modern Healthcare, July 16, 2015, http://www.modernhealthcare.com/article/20150716/NEWS/150719922.

insurance companies and third party administrators.[7] This information can help employers, including self-funded employers, understand how the benefits they offer compare with those offered by other employers in the state, and how they can lower the cost of providing coverage for their employees in New Hampshire.

The usefulness of the NH HealthCost website will be significantly diminished if the Insurance Department can no longer obtain claims data from state-regulated entities that administer plans on behalf of self-funded employers. More than half of New Hampshire residents with privately-funded health coverage receive coverage through a self-funded employer plan that is administered by an insurance company or other state-regulated entity, and these claims have always been part of New Hampshire's claims database.[8] Were a ruling in this

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[7] The "Health Costs for Employers" section of the NH HealthCost website includes a link to the NHID's 2013 NH Market Report, *supra* n.5, which includes summary market statistics on premiums, plan design and benefit richness, as well as information about the market share of insurance carriers, including those acting as third-party administrators.

[8] As of the spring of 2014, 531,844 New Hampshire residents had health coverage not from Medicaid/Medicare, and of these 291,388 were covered through self-funded plans. *See* Wakely Report on NH Health Insurance Markets, August 18, 2014, Table 3.1.1, http://www.nh.gov/insurance/reports/documents/wakely_ma_rpt_pr.pdf. The 2013 NH Market Report showed a similar distribution of fully-insured and self-insured membership. 2013 NH Market Report at 28, Table 26, *supra* n.5.

case to call into question the obligation of a New Hampshire insurance company, health maintenance organization ("HMO") or third-party administrator ("TPA") to report claims data associated with self-funded ERISA plans, or even potentially the data of an employer purchasing fully-insured coverage, the state would lose a valuable resource that has contributed to the development of private market solutions to the problem of rising health costs.

SUMMARY OF ARGUMENT

The Second Circuit's holding that Vermont's health claims reporting law is preempted because it implicates the core ERISA function of "reporting" is based on a fundamental misunderstanding of the nature of claims data reporting, the purposes of ERISA, and the character of ERISA preemption. The application of Vermont's health claims data reporting law to the health plan operated by Liberty Mutual Insurance Co. ("Liberty Mutual") is not preempted under ERISA, because the reporting obligation under the law arises only after the plan's claims have already been adjudicated and paid by Liberty Mutual's TPA, Blue Cross Blue Shield of Massachusetts ("Blue Cross").

Under this Court's reading of section 514 of ERISA, state laws are preempted if they "relate to" plan administration in a way that would interfere with an employer's ability to administer its employee

benefits uniformly across the country. Vermont's law does not mandate particular benefit structures or the coverage of particular services, nor does it impose any requirements with respect to the manner, timing or amount of claims payments. Rather, the reporting obligation arises after, and is entirely distinct from, administration of the plan. The reporting itself is performed by Blue Cross, an insurance-regulated entity that is independently responsible under Vermont law for submitting claims data for all the plans it administers for Vermont residents.

New Hampshire's claims data reporting laws, which like Vermont's law require the submission of claims data only after the claims have been adjudicated, represent a new form of insurance regulation – one that uses big data to stimulate market competition. New Hampshire has enacted extensive reporting requirements as part of its Insurance Code, for the express purpose of facilitating the functioning of insurance markets in the state and using market forces to contain costs. These laws are rooted squarely in the authority of the Insurance Commissioner and are binding only on insurance-regulated entities – insurance companies, HMOs, and TPAs. Yet this new effort, unlike states' traditional insurance regulation of solvency, covered benefits and claim processing, has no equivalent within ERISA. This Court's traditional analysis of insurance regulation under ERISA's savings and deemer clause is ill-suited to address the data-driven facilitation of markets in which New Hampshire is engaged. Rather, the standard that is

properly applicable to New Hampshire's law, and to Vermont's, is whether these laws "relate to" operation of an ERISA plan in the first instance.

Because the reporting obligation does not interfere with the administration of the employee benefit plan, either by Liberty Mutual or by Blue Cross, the claims data reporting law does not "relate to" an ERISA plan within the parameters of this Court's interpretation of ERISA. Vermont's claims data reporting law is not preempted, and the judgment of the Second Circuit should be reversed.

ARGUMENT

I. State Laws Are Not Preempted Under ERISA Unless They "Relate To" Core ERISA Plan Functions In A Way That Prevents National Uniformity In Plan Administration.

Congress enacted ERISA to protect employees by creating a uniform system of regulation for employer-sponsored benefit plans, including health plans. ERISA governs the plans' financial status and administration, creating standards of conduct and fiduciary obligations associated with the management of funds and the administration of claims, as well as reporting obligations and remedies designed to ensure financial solvency and fair treatment of plan participants. *See, e.g.*, 29 U.S.C. § 1001(b) (Congressional findings and declaration of purpose). Consistent with the law's purpose, ERISA's reporting requirements pertain to

the plan's financial status. 29 U.S.C. § 1021(b), (c) and (g) (filing of annual, terminal and supplementary reports with Secretary of Labor; reporting by multiple employer welfare arrangements); 29 U.S.C. § 1023 (details of annual reports).[9] In order to allow uniform plan administration for employers operating in multiple states, Congress included a provision specifying that ERISA preempts all state laws "insofar as they may now or hereafter relate to any employee benefit plan." ERISA § 514(a), 29 U.S.C. § 1144(a).

The broad reach of preemption under ERISA has been narrowed by this Court's rulings. In *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, this Court observed that the expansive language of ERISA is still subject to "the starting presumption that Congress does not intend to supplant state law." 514 U.S. 645, 654 (1995) ("*Travelers*"). Acknowledging that a broad reading of the term "relate to" could result in more sweeping preemption than Congress intended, the Court looked to ERISA's central objective of eliminating the threat

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[9] The other requirements under ERISA's Reporting and Disclosure Part relate to notices and disclosures, not to reporting. ERISA requires plan administrators to provide plan participants and beneficiaries with summary plan information, and with notice of a variety of financial circumstances and transactions. *See, e.g.*, 29 U.S.C. § 1023(a) (summary plan description); (d) (notice of failure to meet minimum funding standards); (e) (notice of transfer of excess pension assets to health benefits accounts) and (f) (defined benefit plan funding notices).

of conflicting and inconsistent state and local regulation of plans governed by ERISA. *Id.* at 657 Surveying the cases in which state laws had been found to be preempted, the *Travelers* Court noted that "[i]n each of these cases, ERISA pre-empted state laws *that mandated employee benefit structures or their administration.*" *Id.* at 658 (emphasis added).[10] State laws providing alternative enforcement mechanisms are also preempted. *Id.*

In keeping with the traditional regulatory role of the states with respect to insurance, ERISA includes a "savings clause" for insurance laws, as well as a "deemer clause" that prevents states from treating self-funded employers themselves, as opposed to the insurance carriers with whom they contract, as being subject to state insurance regulation. 29 U.S.C. §§ 1144(b)(2)(A) and (B).[11] The insurance savings

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[10] This Court has ruled that state laws are also preempted if they contain a "reference to" an ERISA plan, *see Donegan*, 746 F.3d at 508, n.9; however, in this case there is no allegation of such a basis for preemption.

[11] The Eleventh Circuit has outlined the steps involved in an analysis of these clauses of ERISA:

> [I]n determining whether a challenged law is expressly preempted under Section 514 of ERISA, we first look to whether it 'relates to' employee benefit plans. If it does not, the law is not preempted. If it does 'relate to' employee benefit plans, we then turn to whether the law is 'saved' by the Savings Clause. If saved, we must determine whether the Deemer Clause applies. If the Deemer Clause applies, then the

(Continued on following page)

clause is relevant because of the implications of this case for insurance regulation in states like New Hampshire, where health claims information is gathered and used as part of the state's regulation of insurance. Examining the way this Court has approached cases involving the savings and deemer clauses is also necessary because Liberty Mutual relies on its status as a self-funded employer in arguing that Vermont's law is preempted as applied to its claims data.

Under this Court's rulings, an insurance law will escape preemption even in a case involving a self-funded ERISA plan so long as the law does not "relate to" administration of the plan, because the first step in the preemption analysis under section 514 of ERISA is always to look at whether the state law "relates to" the plan. Accordingly, this Court has read the deemer clause to preempt the direct application of state insurance laws to a self-funded ERISA plan only when the state regulation "relates to" the plan: "We read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulate insurance' within the meaning of the saving clause. [S]elf-funded ERISA plans are exempt from state regulation *insofar as that regulation 'relate[s] to' the plans.*" *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (emphasis added).

Savings Clause does not serve to protect the law from preemption.

America's Health Ins. Plans v. Hudgens, 742 F.3d 1319, 1330 (11th Cir. 2014).

Thus, nothing in the savings or deemer clauses alters this Court's fundamental approach to ERISA preemption: state laws, including insurance laws, are preempted when they "relate to" the administration of an employee benefit plan, but not when they have only an indirect effect on the plan's administration. *Travelers*, 514 U.S. at 658.

This Court's cases finding ERISA preemption with respect to self-funded ERISA plans have all involved state laws that relate *directly* to the operation or administration of the ERISA plan, including the remedies available to employees enrolled in the plan. In considering whether an HMO physician qualified as an ERISA fiduciary, the Court examined the meaning of the word "plan," noting that "[r]ules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan." *Pegram v. Herdrich*, 530 U.S. 211, 223 (2000). In its ERISA preemption cases, this Court has consistently interpreted section 514's "relate to an employee benefit plan" language as involving interference with the actual administration of benefits. *See, e.g., Egelhoff v. Egelhoff*, 532 U.S. 141, 147-48 (2001) (statute revoking spouse's plan beneficiary designation in the event of divorce preempted because it "binds ERISA plan administrators to a particular choice of rules for determining beneficiary status this statute governs the payment of benefits, a central matter of plan administration"); *Cal. Div. of Labor Stds.*

Enforcement v. Dillingham Constr., N.A., 519 U.S. 316, 328 (1997) (noting that Court's cases finding preemption involved "state statutes that 'mandated employee benefit structures or their administration'"); *Holliday*, 498 U.S. 52, 60 (state law precluding ERISA plan from seeking reimbursement from claimant's tort recovery to offset medical payments preempted; requiring plan providers to comply with such laws in every state "would complicate the administration of nationwide plans"); *see also America's Health Ins. Plans v. Hudgens*, 742 F.3d 1319, 1331 (11th Cir. 2014) (Georgia prompt pay law preempted as to self-funded ERISA plans, because the law specifies the timeframes in which the plan must process and pay provider claims, or notify claimants of claim denials).

In sum, under this Court's rulings, the first step in determining whether Vermont's data reporting law is preempted under ERISA is to examine whether the law affects the core plan functions outlined in *Pegram*, such as definition of benefits, submission of claims, and resolution of disagreements over entitlement to services. This Court has made clear that state law requirements interfering in such functions with respect to self-funded ERISA plans are preempted under section 514 of ERISA, because they would undercut Congress's goal of allowing national uniformity in the way these plans are administered. Under the same logic, state laws that do not directly affect plan administration are not preempted, whether in the

context of insurance regulation or any other area of state jurisdiction.

II. In New Hampshire, Health Claims Data Reporting Laws Are Part Of The State's Regulation Of Insurance Markets, But Have No Direct Impact On Claim Or Plan Administration.

In the case under appeal, the Second Circuit's analysis rests almost entirely on the principle "that 'reporting' is a core ERISA function shielded from potentially inconsistent and burdensome state regulation." *Liberty Mut. Ins. Co. v. Donegan*, 746 F.3d 497, 508 (2d Cir. 2014). The Second Circuit erred, however, in failing to consider the nature of the reporting required under the state law, or the entity on whom the burden of reporting fell. As noted by the dissent, Vermont's reporting requirement "differs in kind from the 'reporting' that is required by ERISA, and therefore was not the kind of state law Congress intended to preempt." *Id.* at 511 (Straub, J., dissenting in part and concurring in part).

Claims data reporting laws like those in Vermont and New Hampshire involve a type of reporting that falls outside the scope of both ERISA and traditional insurance regulation. The states' traditional regulation of insurance focuses on two main areas: ensuring that insurance companies are solvent and able to pay claims; and ensuring that benefits under the insurance policy are structured and paid in accordance

with any applicable legal requirements. Both of these regulatory areas have equivalents under ERISA, which concerns itself with the financial status of employer plans and preempts state laws governing the administration of plan benefits. In addition, ERISA provides remedies to employees for violations of the plan operator's fiduciary obligations; these preempt statutory and common law remedies that would otherwise be available in state court. *Aetna Health v. Davila*, 542 U.S. 200 (2004). For an ERISA plan, the selection of covered benefits and the processing of claims are governed by the ERISA plan documents and contracts, and are subject to state insurance law requirements only if the plan is fully insured – i.e., if an insurance-regulated entity bears the risk of paying claims under the plan.[12]

New Hampshire's health data claims reporting requirements are part of the state's regulation of insurance markets, but unlike typical insurance laws, they do not regulate the content or administration of insurance plans. New Hampshire's insurance rules contain detailed requirements applicable to claim adjudication for insurance policies issued by an entity

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[12] *See, e.g.*, *Metropolitan Life Ins Co. v. Whaland*, 119 N.H. 894, 901-02, 410 A.2d 635, 639-40 (N.H. 1979) (ERISA does not preempt state insurance laws with respect to an insurance policy purchased by an employer; state law is saved under 29 U.S.C. § 1144(b)(2)(A) even though it relates to an employee benefit plan.).

regulated under state insurance law,[13] but these are separate from the rules governing the submission of claims data, and are not applicable to self-funded ERISA plans.

Claims data reporting in New Hampshire takes place only after a claim has been adjudicated – after the insurance company or TPA has made a determination about whether or not to pay the claim. The administrative rules provide that the data files to be submitted are "composed of service level remittance information *for all adjudicated claims* for each billed medical service provided to members." N.H. Admin. Rules, Ins 4002.01(q) (definition of "medical claims file") (emphasis added). Nothing in the claims reporting rules dictates that claims be adjudicated in any particular manner, only that the data be submitted once the claims have been adjudicated.

New Hampshire's data reporting laws are part of the Insurance Code, Title XXXVII of the state's Revised Statutes Annotated, and were placed by the legislature in N.H. Rev. Stat. Ann. chapter 420-G, which governs the Portability, Availability, and Renewability of Health Coverage. Under New Hampshire's

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[13] *See, e.g.*, N.H. Admin. Rules, Ins chapter 400 (Filings for Life, Accident and Health Insurance); N.H. Admin. Rules, Ins Part 1001 (Claim Settlement for All Insurers, Except Property and Casualty); N.H. Admin. Rules, Ins chapter 1900 (Accident and Health Insurance); N.H. Admin. Rules, Ins chapter 2200 (Health Maintenance Organizations); N.H. Admin. Rules, Ins chapter 2700 (Managed Care).

statute, all health carriers and third-party administrators are required to provide their encrypted claims data electronically to the NHID and the New Hampshire Department of Health and Human Services. N.H. Rev. Stat. Ann. 420-G:11, II. The two agencies are charged with "collaborating in the development of a comprehensive health care information system," commonly referred to as the "CHIS database." N.H. Rev. Stat. Ann. 420-G:11-a, I. The information reported through the CHIS database is used, among other things, to populate the NH HealthCost website.

New Hampshire's claims data reporting law is part of a comprehensive statutory approach aimed at improving market competition through transparency, and rooted in the regulatory authority of the NHID commissioner. The state legislature created the CHIS database for the purpose of increasing transparency in order to enhance consumer choice, foster competition in health insurance markets, and inform public policy decisions. In addition to its placement in the heart of the Insurance Code, the provision's language expressly articulates an intention of using transparency to bring down costs:

> the data shall be available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to

> make informed and cost-effective health care choices.

N.H. Rev. Stat. Ann. 420-11-a, I. Under other sections of New Hampshire's Portability, Availability, and Renewability of Health Coverage law, the NHID has authority to require carriers to submit additional information about their coverage and product design, which the NHID uses to, among other things, hold an annual hearing and produce an annual report on health markets and premium rate trends. N.H. Rev. Stat. Ann. 420-G:14-a, I-III.

New Hampshire's use of the claims data is specifically focused on lowering health costs. By law, the NHID is obligated to compile and use data about New Hampshire's health markets in connection with an annual hearing "concerning premium rates in the health insurance market and the factors, including health care costs and cost trends, that have contributed to rate increases during the prior year." N.H. Rev. Stat. Ann. 420-G:14-a, V. Specifically, the NHID commissioner:

> shall identify variations in the price that health carriers pay for health care services and shall undertake further analysis to determine whether the observed price variations correlate to the sickness or the complexity of the population served, the relative proportion of patients on Medicare or Medicaid that are served by the health care provider, the cost to the health care provider of delivering the service, or the relative

> proportion of free or reduced care provided to the uninsured.

Id. The commissioner has authority to compel health carriers and third-party administrators to testify at the public hearing, and to "produce documents and information deemed necessary and relevant to evaluate the factors that contribute to cost growth in health care services, increased utilization of health care, and health insurance premium costs." *Id.* The commissioner is also responsible for preparing an annual report "which identifies and quantifies health care spending trends and the underlying factors that contributed to increases in health insurance premiums." N.H. Rev. Stat. Ann. 420-G:14-a, VI(a).

The comprehensive approach to market regulation laid out in the New Hampshire statutes can be successful only if the data being analyzed includes that of self-funded employers. New Hampshire's levels of employer-based coverage are the highest in the country, and self-funded employer plans are the source of coverage for more than half of those state residents whose health coverage is not publicly funded through Medicare or Medicaid.[14] Therefore, this case threatens not only the commissioner's ability to obtain data for NH HealthCost, but his ability to obtain necessary information from the

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[14] NHID 2012 Annual Report on Cost Drivers, December 2013, at 9, http://www.nh.gov/insurance/reports/documents/nhid_ann_rrhrng_2013rpt.pdf.

entities he licenses in order to carry out his other responsibilities set forth in N.H. Rev. Stat. Ann. 420-G:14-a.

New Hampshire's law does not require the submission of claims data directly by a self-funded plan or a health care provider, but rather by the insurance-regulated entity that administers the plan's claims. The statute applies only to "health carriers, licensed third party administrators, and any entity required to be registered with the commissioner pursuant to RSA 402-H." N.H. Rev. Stat. Ann. 420-G:11, II.[15] Employers are excluded from New Hampshire's definition of third-party administrator. N.H. Rev. Stat. Ann. 402-H:1, I(a).[16] However, insurance-regulated entities involved in claims administration must include the claims data for self-funded employers whose claims they administer.[17] The NHID's

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[15] N.H. Rev. Stat. Ann. 402-H:11-a allows registration as an alternative to licensure for certain claims administrators.

[16] Similarly, the administrative rules governing the submission of claims data impose no reporting obligations on a "plan sponsor," a definition that includes employers, but only on a "carrier" or a "third party administrator." N.H. Admin. Rules, Ins 4005.01 (filing requirement); Ins 4002.01(e),(w) and (ad) (definitions), effective July 10, 2015.

[17] Because New Hampshire's claims reporting law is part of the state's system of insurance regulation, authority for enforcing it rests solely with the NHID commissioner. The chapter's penalties section provides that:

> [a]ny health carrier who. shall in any way violate this chapter may I. Be prohibited from marketing, selling, or otherwise administering to the individual

(Continued on following page)

administrative rules governing the submission of claims data have long made clear that carriers, including carriers acting as third party administrators, are responsible for submitting claims data for all New Hampshire residents whose claims they administer:

> Beginning on June 1, 2005, and continuing thereafter in accordance with the submission schedule set forth in Ins 4005.05, each carrier and each health care claims processor shall submit to the NHID and to the DHHS, or their designee, a completed health care claims data set for all residents of New Hampshire and for all members who receive services under a policy issued in New Hampshire. Data submission requirements apply to members that meet either criterion.

> or small employer market II. Be subject to an administrative fine not to exceed $2,500 for each violation[; and/or] III. Have its certificate of authority indefinitely suspended or revoked at the discretion of the commissioner.

N.H. Rev. Stat. Ann. 420-G:16. When carriers have failed to submit data, the NHID has proceeded with enforcement action under the insurance laws to obtain compliance, and has issued at least one show cause order scheduling a hearing under N.H. Rev. Stat. Ann. 400-A:17 for such a violation. Order to Show Cause and Notice of Hearing, New Hampshire Insurance Department, In re: Celtic Insurance Company, Docket No. 12-041-EP, available at http://www.nh.gov/insurance/legal/enforcement/documents/12-041-ep.pdf.

Former N.H. Admin. Rules, Ins 4004.01(a); *see also* N.H. Admin. Rules, Ins 4005.01 (effective July 10, 2015).

While the claims data reporting requirements are detailed and technical, they are very familiar to insurance-regulated entities, which already maintain their data in a format compatible with state data reporting requirements. In 2013, out of 363,945 self-funded members in New Hampshire, 362,843 had their claims administered by Anthem, Cigna, Harvard Pilgrim or Aetna, each of which also wrote a substantial amount of fully-insured coverage in the state.[18] Thus, in New Hampshire, the vast majority of self-funded plans are administered by licensed insurance companies or HMOs, large entities which are already subject to New Hampshire's claims reporting requirement with respect to their fully-funded coverage, so data for self-funded members can be submitted via the same systems these companies are already using.

III. New Hampshire's Successful Transparency Efforts Could End If This Court Rules That Vermont's Law Is Preempted

A ruling that Vermont's law is preempted would have a devastating effect on New Hampshire's efforts to regulate its insurance markets using transparency.

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[18] 2013 NH Market Report at 28, Table 26, *supra* n.5.

Because New Hampshire's approach is a novel one outside the scope of traditional insurance regulation, the claims data submission requirement would likely fail this Court's current test for determining whether an insurance law is "saved" from ERISA preemption. Under *Ky. Ass'n of Health Plans v. Miller*, 538 U.S. 329 (2003), a law is "saved" as regulating insurance under ERISA § 514(b)(2)(A) if it (1) is "specifically directed toward entities engaged in insurance," and (2) "substantially affect[s] the risk pooling arrangement between the insurer and the insured." *Miller*, 538 U.S. at 341-42. Because it affects the risk pooling arrangement between insurer and insured through the facilitation of market forces and not through requirements addressing rates or benefits, it is unclear whether New Hampshire's data submission statute would pass the second prong of the *Miller* test, even as to fully-insured insurance policies purchased by an employer.

Halting New Hampshire's progress toward health cost transparency would be a huge step backwards for competitiveness in the state's insurance markets. New Hampshire's experience with the CHIS database, including its creation of the NH HealthCost website, has yielded results consistent with the statutory goal of using transparency to increase competition and allowing consumers and employers to make informed and cost-effective health care choices. The availability of data through NH HealthCost has enabled insurance carriers to better understand the market price for health care services,

encouraging competition in a historically non-competitive market.[19] Health insurance premiums are largely the result of the prices paid for health services. With no information available on the price of health care services, it is virtually impossible for a small carrier to evaluate its competitiveness in the market. Likewise, without transparency, health care providers are placed in the difficult position of attempting to maximize revenues while remaining competitive with other health care providers, something that is virtually impossible without data on the typical amounts paid for the services they offer.

Reports created and commissioned by the NHID using the claims data suggest that transparency has indeed facilitated competition among health insurance carriers and health care providers. As the CHIS data began to be available, the NHID outlined the potential usefulness of the data to the functioning of markets in the state.[20] Two reports issued two and a half years apart show the markets responding to the

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[19] *See* Tu, Ha and Rebecca Gourevitch, *Moving Markets: Lessons from New Hampshire's Health Care Price Transparency Experiment*, April 2014 (Robert Wood Johnson Foundation/ California Healthcare Foundation), http://www.mathematica-mpr.com/our-publications-and-findings/publications/moving-markets-lessons-from-new-hampshires-health-care-price-transparency-experiment.

[20] *NHCHIS and Population Based Risk Adjustment: Looking Beyond Health Cost*, March 20, 2008 (New Hampshire Insurance Department), http://www.nh.gov/insurance/reports/documents/nhchis.pdf.

availability of claims data; public release of information about the various discounts from charges carriers had negotiated with health care providers appears to have influenced carrier market share.[21] Other reports created using the CHIS data detailed particular market developments, such as the increases in member cost sharing over time, the cost of various health insurance mandates (or cost sharing mandates), hospital cost shifting and the impact on the private insurance market, the aging of the population in New Hampshire and its impact on health insurance costs, various cost drivers such as cesarean-section rates, ambulance payment levels, and the relative costs of various hospitals.[22] In addition, the NHID has worked to incorporate its use of the claims data into its evaluation of carriers' proposed premiums through the rate review process.[23] In late 2015,

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[21] *Payments to Providers Part II: Another Look at Carrier Discounts*, August 30, 2012 (New Hampshire Insurance Department) http://www.nh.gov/insurance/reports/documents/nhid_prov_disc_study_partII.pdf; *Payments to Providers: An Inside Look at Carrier Discounts*, January 28, 2010 (New Hampshire Insurance Department), http://www.nh.gov/insurance/reports/documents/pay_prov.pdf.

[22] The NHID website contains links to a variety of reports that were created by or on behalf of the NHID using the CHIS data and other data collected pursuant to N.H. Rev. Stat. Ann. chapter 420-G, including those cited in notes 5, 18-19, 21-22, and 24. A full list of these reports is available here: http://www.nh.gov/insurance/reports/index.htm.

[23] *Analysis of Data Sources to Support Rate Review*, January 2013 (Compass Health Analytics, on behalf of the New

(Continued on following page)

cost data on medical, dental, and prescription drug services will be available in the public domain, effectively improving the efficiency of the market for these services as well.

The usefulness of the NH HealthCost website will be virtually eliminated if the Insurance Department can no longer obtain claims data with respect to the plans offered by ERISA-regulated employers. Losing the claims data not only for self-funded employer plans, but also for fully-insured plans purchased by ERISA-regulated employers, would undercut the benefits the state has achieved through transparency regarding the charges billed for medical procedures performed on New Hampshire citizens, as a way to empower consumers and employers, increase competition in the state's health insurance markets, and encourage innovative health plan designs that incentivize the use of lower-cost providers. Moreover, employers themselves will lose the substantial benefits they have achieved from having access to the information on the NH HealthCost website, the benefit of the market analysis performed by and on behalf of the NHID using the claims data, and the development by insurance companies of innovative product designs, including designs available to self-funded ERISA plans for the administration of these employers' claims.

Hampshire Insurance Department) http://www.nh.gov/insurance/reports/documents/compass-haofda.pdf.

IV. Vermont's Data Reporting Law Is Similar To New Hampshire's From An Operational Perspective, In That Claims Data Reporting Occurs Only After Claim Adjudication.

In order to determine whether a state law is preempted under ERISA, it is important to understand with precision the manner in which the state law operates, and specifically how, if at all, the law affects the administration of ERISA plans. *See, e.g.*, *Travelers*, 514 U.S. 645 at 658-62 (detailed analysis of operation of state law and its connection with ERISA plans). Vermont's data collection law, like New Hampshire's, aims to create a resource for insurers, employers, providers and purchasers of health care. Vt. Stat. Ann. tit. 18, § 9410(h). It requires the filing of health insurance claims data, with provision for the protection of subscriber confidentiality. Vt. Stat. Ann. tit. 18, § 9410(a)(1), (c)-(d).[24]

Vermont's law, like New Hampshire's, is aimed at insurance industry participants; it imposes its reporting obligation on health insurers, as well as on state agencies. Vt. Stat. Ann. tit. 18, § 9410(h)(1)(A) and

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[24] Both the Vermont and New Hampshire claims data reporting laws require compliance with HIPAA, the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 300gg, 29 U.S.C. §§ 11181 *et seq.*, and 42 U.S.C. §§ 1320d *et seq.*, and both shield personally identifiable information from public disclosure. Vt. Stat. Ann. tit. 18, § 9410(a)(1), (c)-(d); N.H. Rev. Stat. Ann. 420-11-a, I. This statutory language is consistent with regulations adopted under HIPAA, which allow disclosures of health information to the extent required by law. 45 CFR 164.512(a).

(C).[25] These entities already have full access to the claims data, as they are responsible for claims administration. As insurance-regulated entities, they are familiar with the form and timing requirements for claims data submission, so there is little additional burden associated with this reporting obligation. In this case, the reporting itself was to be performed by Blue Cross, an insurance-regulated entity that is independently responsible under Vermont law for submitting claims data for all the plans it administers for Vermont residents.

Most significantly, like New Hampshire's data reporting laws, Vermont's claims data reporting laws do not regulate operation of a self-funded ERISA plan itself, but rather impose an obligation to report claims data only *after* the plan's claims have been fully administered. The medical and pharmacy claims data that must be filed under the Vermont law consists of "service level remittance information from all non-denied *adjudicated claims*." Vt. Regulation H-2008-01 (emphasis added).

Vermont's state claims data reporting law, like New Hampshire's, does not mandate particular benefit structures or the coverage of particular services, nor does it impose any requirements with respect to the manner, timing or amount of claims

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[25] The Vermont law also includes the reporting of federal employee claims data, but only "with the agreement of the federal government." Vt. Stat. Ann. tit. 18, § 9410(h)(1)(D).

payments. The claims data reporting does not interfere with any specific provision of ERISA; ERISA's reporting obligations are focused on plan solvency, while ERISA's health-plan-specific provisions concern issues of coverage and claim adjudication. 29 U.S.C. §§ 1021-1031 (Reporting and Disclosure Requirements); 29 U.S.C. §§ 1181-1191c (Group Health Plan Requirements). By contrast, the claims data reporting obligation arises after, and is entirely distinct from, administration of the plan.

V. Data Collection Laws Like Those In Vermont And New Hampshire Are Not Preempted Because They Do Not "Relate To" The Structure Or Administration Of An Employee Benefit Plan Under ERISA.

ERISA preempts state laws that regulate the terms, administration or benefits of an ERISA health plan; it does not preempt state laws that govern matters peripheral to plan operation, even if those laws may have a significant indirect effect, for example by increasing the cost to the employer of maintaining a plan or choosing a particular plan model. *Travelers*, 514 U.S. 645, 658 (1995). The New York law at issue in *Travelers* required hospitals to collect surcharges from patients covered by commercial insurance, but not from patients covered by a Blue Cross/Blue Shield Plan, with the effect of increasing the cost of commercial plans an employer might purchase. Despite this potential for increased cost, the Court found that the law was not preempted by

ERISA, because it did not "bind plan administrators to any particular choice and thus function as regulation of an ERISA plan itself." *Id.* at 659. The surcharge law's "indirect economic influence" did not relate to the plan's administration or benefit structure, the Court concluded; rather, it "simply bears on the costs of benefits and the relative costs of competing insurance to provide them." *Id.* at 659-60. Thus, the Court held that "the provisions for surcharges do not 'relate to' employee benefit plans within the meaning of ERISA's pre-emption provision, section 514(a), 29 U.S.C. section 1144(a), and accordingly suffer no preemption." *Id.* at 649.

This Court has held that under certain conditions, claims administrators qualify as ERISA fiduciaries, resulting in the preemption of state laws regulating their activities as they relate to ERISA plans. In *Aetna Health v. Davila*, 542 U.S. 200 (2004), the Court ruled that ERISA did preempt a Texas law imposing a heightened duty of care on insurance carriers in their handling of coverage decisions. In *Davila*, the insurance carriers were administering claims on behalf of self-funded employer health plans governed by ERISA. The Court ruled that plan enrollees could not bring a state-law action against the carriers, reasoning that carriers acting as TPAs had no independent duty to the enrollees, but rather were obligated to administer claims in strict accordance with the terms of the ERISA plan. *Davila*, 542 U.S. at 212-13. Thus, the enrollees' claims were inextricably tied to their employers' fiduciary duties under ERISA,

such that only ERISA remedies were available to the enrollees. *Davila*, 542 U.S. at 214.

Vermont and New Hampshire's claims data reporting requirements are very different from the Texas law that was challenged in *Davila*; that law governed the actual administration of the claim, not the submission of data after the claim had been administered. Similarly, in *Pharm. Care Mgt. Ass'n v. Rowe*, 429 F.3d 294 (1st Cir. 2005), *cert. denied*, 126 S. Ct. 2360 (2006), the First Circuit Court of Appeals considered whether ERISA preempted a Maine law requiring pharmacy benefit managers ("PBMs") to act as fiduciaries to their clients, including self-funded ERISA plans. Distinguishing *Davila*, the circuit court concluded that the law was not preempted, because the PBMs, which did not "exercise discretionary authority or control in the management or administration of the plan," were not fiduciaries under ERISA. *Rowe*, 429 F.3d at 301. Nor did the state law compel the administrators of the plan to structure their benefits in a particular manner:

> This is not an instance, such as that confronted by the Supreme Court in *Egelhoff*, where the plan administrators were *bound* to a particular choice of rules – rules mandated by the state for determining beneficiary status. The plan administrators here have a free hand to structure the plans as they wish in Maine.

Rowe, 429 F.3d at 303 (emphasis in original). Thus, the court concluded, the law did not "relate to" an ERISA plan and was not preempted. *Id.*

The Vermont and New Hampshire claims data reporting laws are far more similar to the law that was found not to be preempted in *Rowe* than the law that was held to be preempted in *Davila*. Vermont's law does not govern the administration of benefits or remedies of ERISA plans, including the benefits provided or the management of claims payments. As with the surcharge law in *Travelers*, the obligation to report claims data does not "relate to" the administration, benefits or remedies associated with a plan regulated under ERISA. Unlike the Texas law at issue in *Davila*, the reporting law does not conflict in any respect with the terms of the ERISA plan, because it imposes no requirements that relate to covered services or the administration of the plan, and provides no alternative remedy to plan enrollees. Ruling that these requirements are preempted would be inconsistent with this Court's interpretation of ERISA, because they bear no relation to the administration of benefits under an ERISA plan.

CONCLUSION

In enacting ERISA, Congress cannot have intended to eliminate state innovations like using transparency and market competition to control health costs, as New Hampshire has done through its

CHIS database and NH HealthCost website. New Hampshire's claims data reporting laws have no equivalent within ERISA; Congress enacted that law to govern plan solvency and benefit administration, not to regulate insurance markets, which is the traditional province of the states. New Hampshire's initiative has been beneficial to consumers and employers alike – but these gains will be lost if this Court finds that Vermont's law is preempted.

Both Vermont's and New Hampshire's claims data laws require submission of data only after the claims have been adjudicated, and do not impose requirements with respect to claims administration. Because Vermont's reporting law does not interfere in any way with administration of Liberty Mutual's employee benefit plan, it does not "relate to" an ERISA plan within the parameters of this Court's interpretation of ERISA. Vermont's claims data reporting law is not preempted, and the judgment of the Second Circuit should be reversed.

Respectfully submitted,

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No. 14-181

Supreme Court, U.S
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IN THE

Supreme Court of the United States

ALFRED GOBEILLE, IN HIS OFFICIAL CAPACITY AS CHAIR OF THE VERMONT GREEN MOUNTAIN CARE BOARD,

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE STATES OF NEW YORK, COLORADO, CONNECTICUT, HAWAI'I, ILLINOIS, KANSAS, MAINE, MARYLAND, MASSACHUSETTS, MINNESOTA, NEBRASKA, OREGON, RHODE ISLAND, TENNESSEE, TEXAS, UTAH, AND WASHINGTON, AND THE DISTRICT OF COLUMBIA, AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

Many States require health care payers to report certain data about paid medical claims to state databases, which are used to develop and evaluate evidence-based health care policies. These state laws apply equally to traditional health insurance plans, self-funded plans, and government programs such as Medicare.

The question presented is:

Whether ERISA preempts a state health care data collection law as applied to a self-funded ERISA benefit plan, even though the law does not implicate ERISA's objectives or interfere with its requirements.

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INTEREST OF THE *AMICI* STATES

All-payer claims databases (APCDs) are an important tool for States' efforts to develop and evaluate evidence-based health care policies. An APCD assembles anonymized statistical information about each medical claim paid in a State, permitting the State to analyze the safety, efficacy, availability, and cost of the medical services available to its residents. Eighteen States have enacted statutes that mandate reporting of claims data to their APCDs,[1] and at least twenty-two other States have demonstrated interest in creating similar databases.[2]

This amicus brief is filed on behalf of the States of New York, Colorado, Connecticut, Hawai'i, Illinois, Kansas, Maine, Maryland, Massachusetts, Minnesota, Nebraska, Oregon, Rhode Island, Tennessee, Texas, Utah, and Washington, and the District of Columbia.

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[1] *Arkansas*: Ark. Code Ann. §§ 2[illegible]61-904, -906; *Colorado*: Colo. Rev. Stat. § 25.5-1-204; *Connecticut*: Conn. Gen. Stat. § 38a-1091; *Kansas*: Kan. Stat. Ann. § 65-6804; *Maine*: Me. Rev. Stat. Ann. tit. 22, §§ 8703, 8704; *Maryland*: Md. Code Ann., Health-Gen. § 19-133; *Massachusetts*: Mass. Gen. Laws Ann. ch. 12C, § 12; *Minnesota*: Minn. Stat. Ann. § 62U.04; *Nebraska*: Neb. Rev. Stat. § 71-9202; *New Hampshire*: N.H. Rev. Stat. Ann. § 420-G:11-a; *New York*: N.Y. Pub. Health L. §§ 206(18-a), 2816; *Oregon*: Or. Rev. Stat. § 442.466; *Rhode Island*: R.I. Gen. Laws § 23-17.17-10; *Tennessee*: Tenn. Code Ann. § 56-2-125; *Utah*: Utah Code Ann. § 26-33a-106.1; *Vermont*: Vt. Stat. Ann. tit. 18, § 9410; *Washington*: Wash. Rev. Code Ann. § 43.371.020; *West Virginia*: W. Va. Code § 33-4A-2.

[2] These States are Alaska, Arizona, California, Delaware, Florida, Hawai'i, Idaho, Illinois, Iowa, Kentucky, Louisiana, Michigan, Montana, New Jersey, New Mexico, Ohio, Pennsylvania, South Carolina, Texas, Virginia, Wisconsin and Wyoming. See *infra* at 5.

This case affects every State that operates an APCD or may operate one in the future, because the usefulness of an APCD depends on its comprehensiveness. APCD statutes require health care payers to disclose certain information about every paid claim, typically including the patient's diagnosis, the service provided, the fee paid, the identity of the service provider, and demographic information about the patient (e.g., age, sex and ZIP code). States use this information to improve access to health care, control health care costs, identify unnecessary and potentially dangerous procedures, and regulate health insurance markets. But in order for policymakers and health officials to be able to draw correct statistical inferences from the data, an APCD must include all patient experiences.

Amici States accordingly urge this Court to reverse the decision below, which erroneously held that the preemption clause of the Employee Retirement Income Security Act of 1974 (ERISA) exempts self-funded insurance plans from APCD reporting requirements.[3] Employees covered by self-funded plans constitute about sixty percent of privately insured Americans, and are on average younger and healthier than people with other kinds of coverage. *See* Emp. Benefit Research Inst., *Self-Insured Health Plans: State Variation and Recent Trends By Firm Size*, Notes, Nov. 2012, at 1; Robert Pear, *Employers With Healthy Workers Could Opt Out of Insurance Market, Raising Others' Costs*, N.Y. Times, Feb. 18,

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[3] A self-funded plan is one in which an employer assumes the cost and risk of paying for its employees' health care instead of contracting that risk to an outside health insurance company.

2013, at A9. If self-funded plans are exempt from reporting their claims data to APCDs, the information in the resulting databases will be limited to Americans covered by traditional commercial insurance, Medicare, and Medicaid. That will skew the data in the APCDs toward the experiences of demographic groups more heavily represented by those forms of coverage. Furthermore, because Americans are likely to change insurance plans several times over the course of their lives, the omission of data from self-funded plans will make it difficult to track treatments and disease progressions over time.

Amici States also share an interest in protecting the States' broad authority over health care regulation, which ERISA did not displace. As this Court has made clear, Congress enacted ERISA for the benefit of employees, not to shield plans from state laws of general applicability that are unrelated to ERISA's objectives and do not interfere with ERISA duties. APCD laws do not implicate the administration of ERISA plan benefits or intrude on the federal government's fiscal oversight of plans. Rather, APCD laws occupy a wholly different sphere from ERISA. There is no tension between the two warranting preemption.

STATEMENT OF THE CASE

1. Congress enacted ERISA in 1974 to guarantee "the continued well-being and security of millions of employees and their dependents." 29 U.S.C. § 1001(a). ERISA "establish[es] standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans." *Id.* § 1001(b). To make it more

practical for employers and plan administrators to comply with those requirements, ERISA's provisions "supersede any and all State laws insofar as they . . . relate to any employee benefit plan." *Id.* § 1144(a).

For more than two decades, this Court has resolved ERISA preemption challenges by considering the "objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995). ERISA preemption does not reach "traditionally state-regulated substantive law in those areas where ERISA has nothing to say." *Cal. Div. of Labor Standards Enf't v. Dillingham Constr., N.A.*, 519 U.S. 316, 330 (1997).

2. States have used health data collection to help develop evidence-based public health policies since the earliest days of the Republic. State data collection initiatives have included mandatory reporting of infectious diseases, statewide cancer registries, and collection of hospital discharge data. Building on these past efforts, many States have in more recent decades enacted laws requiring data about paid health care claims to be reported to a state-run all-payer claims database.

Maine created the Nation's first APCD in 2003, and since that year has collected claims data from all private payers (including self-funded plans), Medicaid, Medicare, and pharmacy managers. *See* Me. Health Data Org., *The All Payer Claims Database*. Over the next two years, Kansas and New Hampshire established similar databases. *See* APCD Council, *Interactive State Report Map* (links to listed States) ("*Interactive Map*"). As of September 2015, mandatory

APCDs are fully operational in a total of thirteen States,[4] and five more States with mandatory-reporting statutes are in the process of implementing their databases.[5] Three States collect limited claims data on a voluntary basis,[6] and nineteen States that do not yet have APCD statutes have demonstrated an interest in creating databases by conducting feasibility studies, introducing proposed legislation, or obtaining funding grants.[7]

Creation of an APCD is an expensive undertaking requiring several years of work. After a State enacts an APCD statute, policymakers must coordinate with payers, providers, employers and health insurance exchanges to ensure efficient data collection. *See* APCD Council, *The Basics of All-Payer Claims Databases* 3-5 (Jan. 2014). For example, New York began collecting data from insurers on its state-run health insurance exchange in early 2015, but is still working to phase in data from Medicaid plans and non-exchange private payers. *See* N.Y. Dep't of

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[4] Mandatory APCDs are operational in Arkansas, Colorado, Kansas, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, Oregon, Rhode Island, Tennessee, Utah, and Vermont. *See* APCD Council, *Interactive Map*, *supra*.

[5] Mandatory APCDs are at the implementation phase in Connecticut, Nebraska, New York, Washington and West Virginia. *See* APCD Council, *Interactive Map*, *supra*.

[6] Data is collected voluntarily in California, Virginia, and Wisconsin. *See* APCD Council, *Interactive Map*, *supra*.

[7] Interest in APCDs has been shown by Alaska, Arizona, Delaware, Florida, Hawai'i, Idaho, Illinois, Iowa, Kentucky, Louisiana, Michigan, Montana, New Jersey, New Mexico, Ohio, Pennsylvania, South Carolina, Texas, and Wyoming. *See* APCD Council, *Interactive Map*, *supra*.

Health, *All Payer Database*. As of September 2015, at least ten States collect data from self-funded plans,[8] and others are preparing to do so in the future.

3. The actual task of collecting and reporting data from self-funded plans falls on the third-party administrators (TPAs) who process claims on their behalf. Blue Cross Blue Shield of Massachusetts (BCBSMA) is the TPA for the Liberty Mutual Medical Plan, a self-funded plan created to benefit employees and retirees of respondent Liberty Mutual Insurance Company. Pet. App. 50. In August 2011, when Liberty Mutual filed this declaratory judgment action asserting that ERISA preempts Vermont's APCD law, it ordered BCBSMA to stop reporting claims data for the 137 Vermonters on its plan. Pet. App. 56. BCBSMA now strips that data from reports submitted to Vermont's APCD, but complies with APCD reporting requirements in every other instance. Pet. App. 56, 72 & n.5; *see also* BCBSMA, *Third Party Administration* (2010).

The district court entered summary judgment in favor of Vermont, holding that because States have traditional authority over "the health care field," APCD statutes are entitled to a presumption against preemption even if they "do[] not directly regulate health care providers or services." Pet. App. 65-66 (citing *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814-15 (1997)). The court also found the reporting of APCD data to be "peripheral to

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[8] The States that collect self-funded data include at least Maine, Maryland, Massachusetts, Minnesota, New Hampshire, Oregon, Tennessee, Utah, Vermont, and West Virginia. *See* APCD Council, *Interactive Map*, *supra*.

the core ERISA functions" and any administrative burden minimal. Pet. App. 78-79.

In reversing, the Second Circuit held that Vermont cannot compel self-funded plans to report data to the State's APCD because ERISA already requires such plans to report other, different kinds of data. Pet. App. 23-29. Notwithstanding *De Buono*'s presumption against preemption of state laws operating in the *field* of health care, the court below assumed that the presumption applies only to state laws that *directly regulate* health care services. Pet. App. 18 n.8. And notwithstanding *Travelers*' instruction that ERISA's objectives dictate the scope of ERISA preemption, the court assumed that the categorical differences between the reporting requirements of ERISA and Vermont's APCD law were a reason why the latter *should* be preempted. Pet. App. 24 n.11. A dissenting opinion criticized both of these assumptions, adding that Liberty Mutual had made no effort to show it was burdened by sharing data that it and its TPA already collect. Pet. App. 31-34, 39 (Straub, J., dissenting).

SUMMARY OF THE ARGUMENT

The central purpose of APCD laws is to promote the safe and effective provision of health care through more informed policymaking. This Court's precedents foreclose any argument that the presumption against preemption applies only to laws that *directly* regulate health care services. Furthermore, contrary to the assumption of the court below, APCD statutes are part of a long tradition of state health data collection, and thus fall comfortably

within the scope of the States' historic oversight of health care.

In any event, ERISA preempts only state laws that intrude on its objectives or directly conflict with its requirements. APCD laws do not attempt to regulate the relationships that ERISA regulates (i.e., among plans, participants, administrators, employers, and trustees) and thus do not implicate ERISA's core purposes. And because APCD laws do not interfere with the choices that ERISA plans must make when administering or paying plan benefits, they do not conflict with ERISA's requirements. In holding that ERISA preempts all state laws that mandate any form of "reporting" by self-funded plans—however unrelated to ERISA's reporting requirements—the court below erroneously approached ERISA preemption with the "'uncritical literalism'" that this Court has repeatedly rejected. *Dillingham*, 519 U.S. at 325 (quoting *Travelers*, 514 U.S. at 656).

ARGUMENT

I. APCDs Are Entitled to a Strong Presumption Against Preemption Because States Use Them to Regulate Health Care, a Traditional Responsibility of State Government.

It is well-settled that the ERISA preemption analysis should begin with a presumption against preemption, *see De Buono*, 520 U.S. at 813, particularly in "fields of traditional state regulation," *Travelers*, 514 U.S. at 655. ERISA thus should not be held to preempt state laws in the historically state-regulated field of health care "unless that was the clear and manifest purpose of Congress." *Travelers*, 514 U.S. at 655; *accord De Buono*, 520 U.S. at 813

n.8. This strong presumption applies to any law that operates in the health care field, and not merely to laws that directly regulate how services are provided. *See De Buono*, 520 U.S. at 814.

The Second Circuit declined to apply that presumption here, on the grounds that APCD laws "do not regulate the safe and effective provision of health care services." Pet. App. 18 n.5. But APCD laws were enacted to provide States with the data needed to pursue evidence-based health care policies, and thus are an important tool in States' exercise of their historic police power over health care.

A. All-Payer Claims Database Laws Provide States With Crucial Evidence to Improve Health Care Policy.

APCD laws require health care payers to report certain data about paid medical claims to a statewide database. That data includes the diagnosed condition, the procedure performed, the identity of the provider, the amount paid for the service, demographic information about the patient (e.g., age, sex, and ZIP code), and the patient's type of insurance coverage (e.g., Medicare, Medicaid, or private insurance). *See* APCD Council, *The Basics*, *supra*, at 2.

The Vermont program at issue here is representative. *See* Vt. Stat. Ann. tit. 18, § 9410 (*reproduced at* Pet. App. 92-99). It requires "[h]ealth insurers, health care providers, health care facilities, and governmental agencies" to report all "health insurance claims" to a statewide database. *Id.* § 9410(c)(1) (*reproduced at* Pet. App. 94). "Health insurers" are defined to include the TPAs who process claims on behalf of self-insured employers.

Code Vt. R. 21-040-021 H-2008-01 § 3(X) (*reproduced at* Pet. App. 112-13). Health insurers must provide the database with the data from each paid medical claim, *id.* § 4(D). Once collected, the data is "available as a resource for insurers, employers, providers, purchasers of health care, and State agencies to continuously review health care utilization, expenditures, and performance." Vt. Stat. Ann. tit. 18, § 9410(h)(3)(B). The APCD laws of other States take a similar approach.[9] States either require payers to purge personal identifying information about patients from their reports, *see, e.g.*, Code Vt. R. 21-040-21 H-2008-01 § 7(A)(5), or require that such data be released only in encrypted form to prevent identification of individual patients, *see, e.g.*, 90-590 Me. Code R. Ch. 120, § 9(A).

The principal reason States create APCDs is to provide policymakers with information they can use to develop programs that improve the quality of health care while controlling costs. *See* Nat'l Conf. of

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[9] *See, e.g.*, Md. Code Ann., Health-Gen. § 19-133(c) (requiring reporting, "for each type of patient encounter with a health care practitioner," of "(i) [t]he demographic characteristics of the patient; (ii) [t]he principal diagnosis; (iii) [t]he procedure performed; (iv) [t]he date and location where the procedure was performed; (v) [t]he charge for the procedure" and other claim-specific data); *see also* Ark. Code Ann. § 23-61-904; Colo. Code Regs. § 2505-5:1.200.2; Conn. Gen. Stat. § 38a-1091(a)(1); 90-590 Me. Code R. ch. 243, § 2; Mass. Gen. Laws Ann. ch. 12C, § 8(a); Minn. Stat. Ann. § 62U.04, subd. 4; Neb. Rev. Stat. § 71-9204(1)(a); N.H. Code Admin. R. Ins. 4004.01(a); N.Y. Pub. Health L. § 2816(2)(a)(v); Or. Rev. Stat. § 442.466(2)(b)(A); R.I. Gen. Laws § 23-17.17-10(a)(1); Tenn. Code Ann. § 56-2-125(f)(1)(A); Utah Admin. Code R. R428-15-3(1); Wash. Rev. Code Ann. § 43.371.020(1); W. Va. Code R. § 114A-1-5.

State Legislatures, *Collecting Health Data: All-Payer Claims Databases*, Health Cost Containment & Efficiencies 1 (May 2010). Most APCD statutes contain express statements of this purpose. For example, Vermont's statute specifies that regulators should use the database for "identifying health care needs and informing health care policy, . . . evaluating the effectiveness of intervention programs on improving patient outcomes, . . [and] comparing costs between various treatment settings and approaches." § 9410(a)(1). Several other States, including Tennessee, Nebraska, and Oregon, describe the purposes of their databases using statutory language nearly identical to Vermont's. *See* Tenn. Code Ann. § 56-2-125(b)(1); Neb. Rev. Stat. § 71-9202; Or. Rev. Stat. § 442.466(1). Utah's APCD is intended to "assist the Legislature . . . by reporting on geographic variances in medical care and costs . . [and] rate and price increases by health care providers." Utah Code Ann. § 26-33a-106.1(1)(c). Kansas has directed that its data be used "to improve the decision-making processes regarding access, identified needs, patterns of medical care, price and use of health care services."[10] Kan. Stat. Ann. § 65-6801(c).

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[10] Similarly, Massachusetts' APCD statute directs agencies to use the database for "lowering total medical expenses, coordinating care, benchmarking, quality analysis and other research, administrative or planning purposes." Mass. Gen. Laws Ann. ch. 12C, § 12(b). Minnesota uses its data to "reduce avoidable [hospital] readmissions [and] analyze variations in health care costs, quality, utilization, and illness burden based on geographical areas or populations." Minn. Stat. Ann. § 62U.04(11), subds. 2-3. Rhode Island's APCD promotes "new and improved public sector approaches to measuring, evaluating and improving quality." R.I. Gen. Laws § 23-17.17-

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States use APCDs to improve health care in a variety of ways, as the following examples illustrate.

1. States use APCDs to control health care costs.

Nationally, as much as thirty percent of health care spending is wasted. *See* Nat'l Conf. of State Legislatures, *Collecting Health Data*, *supra*, at 1. APCDs help States to make sure that unnecessary procedures are avoided, and that necessary care occurs in the most cost-effective setting.

Minnesota has used its APCD to address the problem of readily preventable emergency room visits and hospital admissions. *See* Minn. Dep't of Health, *Potentially Preventable Health Care Events in Minnesota* (July 2015). By studying its APCD data, Minnesota has determined that two out of three emergency room visits in Minnesota were for conditions that could be treated as effectively in an outpatient setting, and that as many as fifty thousand Minnesotans had four or more preventable ER visits in 2012. *Id.* at 3. Minnesota estimates that, in a typical year, about $2 billion of the $40 billion spent on health care in the State is spent on preventable events. *Id.* at 1-2. Identifying the conditions that typically lead to unnecessary hospital admissions—for example, upper-respiratory tract

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1(3). Virginia's database was "created to facilitate data-driven, evidence-based improvements in access, quality, and cost of health care and to promote and improve the public health through the understanding of health care expenditure patterns and operation and performance of the health care system." Va. Code Ann. § 32.1-276.7:1(A).

infections, back pain, and pneumonia—enables Minnesota to redirect treatment of those conditions to lower-cost outpatient settings. *Id.* at 3.

New York's APCD will soon be used to identify "health care services that are unnecessary, increase costs, and may even endanger [patients'] health." N.Y. Dep't of Health, *New York State All Payer Database Use Cases* 8 (Oct. 2011). A pilot study based on limited data has shown that one in six hysterectomies may be medically inappropriate. *Id.* at 9. Regulators in New York also plan to study expenditures for chronic diseases. For example, a study of fifteen different care coordination programs revealed that two had noticeably fewer hospitalizations. *Id.* Further study revealed that, as compared with patients in programs that reported more patient hospitalizations, patients from those two programs received a greater number of substantial in-person contacts and achieved equivalent health outcomes, but at a much lower cost. *Id.* at 9-10.

2. States use APCDs to regulate local insurance markets.

Federal law establishes a state-federal partnership to ensure that increases in premiums for health insurance are reasonable. *See* 42 U.S.C. § 300gg-94. Insurers who wish to participate in state-run health insurance exchanges must provide justifications for premium increases, and States have primary responsibility for preventing excessive and unjustified premium increases. *Id.* § 18031(e)(2). The U.S. Department of Health and Human Services has strongly encouraged States to use APCDs to perform this rate review function. At least eleven States with mandatory APCD statutes—Arkansas, Kansas,

Maryland, Massachusetts, Minnesota, New York, Oregon, Rhode Island, Utah, Vermont, and Washington—have received approval for HHS grants totaling approximately $ 36 million to develop APCDs for use in rate review. *See* Ctr. for Medicare & Medicaid Servs., *Rate Review Grants*. Two States that do not yet have APCD statutes, California and Hawai'i, have received HHS grants to create such databases in the future. *See id.*

Even before the recent federal reforms, about half the States already had laws giving their insurance commissioners the power to approve or disapprove changes in the premiums that insurers charge for coverage. *See* Nat'l Conf. of State Legislatures, *State Approval of Health Insurance Rate Increases* (Aug. 2015). New York, for example, requires that certain insurers obtain prior state approval before increasing or decreasing a premium rate, and permits regulators to reject unjustified, unreasonable, or excessive changes. *See* N.Y. Ins. Law §§ 3231(e), 4308(b)-(c). New York intends to use its APCD to complement and verify the data that insurers supply to regulators. The APCD data will allow regulators to determine the costs that drive premium increases, both on a statewide and region-by-region basis, and thus confirm that there is a practical justification for a proposed increase. *See* N.Y. Dep't of Health, *New York State All Payer Database*, *supra*, at 17-18.

3. States use APCDs to investigate whether their health care policies are working.

The agency overseeing Maryland's APCD generates two annual reports on health care costs and payment rates, as well as special reports at the

legislature's request. For example, in 2010, Maryland enacted a law that limits a patient's financial liability for treatment received at a hospital from a doctor who is not a preferred provider under the patient's insurance plan, while ensuring that the doctor receives a statutory minimum payment from the patient's insurer. *See* Md. Code Ann., Ins. § 14-205.2. After the statute took effect, the legislature directed regulators to study cost data from the State's APCD to see if the law was having its intended effect. The study found that the law had been largely successful, producing more predictable bills for patients while protecting doctors' payment levels. Md. Health Care Comm'n, *Impact of the Assignment of Benefits Legislation* (2015).

APCD studies can also reveal when legislative goals have not yet been attained. After Maryland required non-radiologist physicians to divest themselves of ownership interests in radiology services and prohibited self-referral of patients to such services, the General Assembly ordered regulators to use the APCD to determine whether the law actually reduced referrals. Md. Health Care Comm'n, *Assessment of Changes in Advanced Imaging Referrals by Orthopedists 2010-2012* (2014). The report concluded that prior to divestment, physicians with a financial stake in imaging services did have higher referral rates than other physicians who did not have ownership interests, but that divestiture did not immediately drive a decrease in those rates. *Id.* at 2.

4. States use APCDs to identify and promote specific prevention and treatment measures.

Utah has used its APCD to improve preventive medicine by studying the preventive and screening care received by its healthiest citizens in each age bracket. Utah Dep't of Health, *Making* Cents *of Utah's Healthy Population*. Utah Atlas of Health Care 3 (Oct. 2010). Colorado—in an effort to confront the nationwide problem of death from opioid overdoses—is using its APCD to study the extent to which lawful prescriptions of opioid analgesics lead to dependence. Focusing on patients with no past exposure to opioids who receive prescriptions for opioid analgesics after major surgeries, researchers are studying the rates at which those patients continue to seek opioid prescriptions at thirty-, ninety-, and 180-day intervals after their discharge from hospitals following major surgery. The goal of the study is to identify classes of patients who would be better served by non-opioid analgesics. Ctr. for Improving Value in Health Care, Project: Identify Opportunities to Reduce Use of Potentially Harmful Medications During and Post Surgery.

Massachusetts is pursuing a number of research initiatives with its APCD data. Like most States, Massachusetts maintains a cancer registry,[11] which contains detailed information about the histology, stage, and date of diagnosis for each tumor diagnosed in the State. But similar to other cancer registries,

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[11] *See infra* at 21 (discussing cancer registries in forty-five States).

the Massachusetts registry generally does not contain information about the medical procedures used in treatment and the costs that those procedures incur. This kind of information is contained in the Massachusetts APCD, however. And by linking its APCD to its cancer registry, Massachusetts can study how the quality, costs and outcomes of care vary across providers, particularly for patients with potentially curable lung, colorectal, breast, and prostate cancer (the four most common causes of cancer-related death). *See* Nat'l Cancer Inst., Project: Linking State Registry and All Payer Claims Data to Study Cancer Care. New York similarly intends to link its APCD to its State Cancer Registry. *See* N.Y. Dep't of Health, *New York State All Payer Database*, *supra*, at 12. In another project, the Massachusetts Department of Public Health is using APCD data to study tobacco cessation methods across demographic and socioeconomic groups, with the goal of determining which methods of quitting smoking are most effective and efficient. *See* Mass. Div. of Health Care Fin. & Policy (now the Massachusetts Center for Health Information and Analysis), Project: Utilization of Tobacco Treatment in Massachusetts to Quit Smoking.

These kinds of studies are effective precisely because they identify the differences in outcomes across demographic groups, income levels, and types of insurance coverage. When researchers identify patients with a given medical need who have better or more cost-effective outcomes than other patients with the same need, they can propose better and more efficient approaches for all patients.

B. APCD Laws Also Improve the Quality and Efficiency of Health Care by Creating Transparency for Consumers and Providers.

Although APCDs originated as a tool for policy-makers, many States make the anonymized claims data they collect available to other stakeholders in the health care industry, including consumers and providers. In almost every sector of the economy, Americans regard data-driven comparison-shopping as a fact of life. Today's consumer has access to tools for comparing the quality and cost of prospective homes, automobiles, and kitchen appliances. But health care, despite accounting for a fifth of the Nation's spending, largely remains an exception. By making APCD data available to consumers themselves, States are in a unique position to fill this information gap.

Colorado, New Hampshire, and Maine have already adapted their APCDs for this purpose. Each State has used its APCD data to create a public website that enables its residents to compare the cost of health care services across providers within the State. *See* Ctr. for Improving Value in Health Care, *CO Medical Price Compare–Research Entity*; N.H. Ins. Dep't, *NH HealthCost*; Me. Health Data Org., *HealthCost*. Several other States, including New York and Maryland, intend to create similar websites. *See* Ctr. for Medicare & Medicaid Servs., *Maryland Rate Review Grants Award*.

A patient visiting the Colorado website can compare costs by selecting a particular kind of health care service, a geographical area, and the kind of insurance to be billed. For example, a patient could

specify that she needs a hip replacement, would prefer a hospital within twenty-five miles of Denver, and expects to bill private insurance. The website would then display the median price of a hip replacement at each hospital within the specified radius for patients using private insurance.[12] The New Hampshire website functions similarly.[13] The Maine website allows consumers to browse the costs of a large number of outpatient and office-visit procedures across providers, and also to see how often each provider performs the chosen procedure in the course of a year. Each of these websites rates providers on the complexity of the procedures they typically perform, enabling patients to understand that in some cases higher prices may reflect a hospital's acceptance of higher-risk procedures.

Similarly, providers can use APCDs to assess the rates that different payers are actually paying for services, and to identify market opportunities that are underserved. The State of Washington encourages providers to use its forthcoming APCD to identify the procedures that residents of rural parts of the State travel long distances to obtain, in order to enhance competition to provide services in the rural areas

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[12] As of August 28, 2015, performing this illustrative search returns median prices as low as $20,797 and as high as $36,446.

[13] New Hampshire, in a separate amicus brief supporting Vermont, describes how NH HealthCost also promotes competition in its insurance markets. *See* Br. for New Hampshire at 3-5, 22-25. By providing insurers with better information about the market price for health care services, New Hampshire promotes competition, "including the development of health plan designs that create incentives for using lower-cost providers." *Id.* at 3.

themselves. *See* Wash., Office of the Gov., *Gov. Inslee Continues Push for Health Care Cost Transparency* (Jan. 29, 2015). The Arkansas database is specifically intended "to promote competition based on value" by promoting price transparency. Ark. Ctr. for Health Improvement, *Arkansas All-Payer Claims Database.*

C. APCD Laws Promote Public Health in a Manner That Fully Qualifies for a Strong Presumption against Preemption.

The court below wrongly assumed that APCD laws are ineligible for a presumption against preemption because they do not *directly regulate* how health care services are provided. *See* Pet. App. 18 n.8. *De Buono* expressly forecloses this gloss on the presumption. Like the New York tax on hospital receipts at issue in *De Buono*, an APCD statute is entitled to a strong presumption against preemption because it "*operates in a field* that has been traditionally occupied by the States." 520 U.S. at 814 (emphasis added) (quotation marks omitted). What matters is the field of operation, not the manner of regulation. *See id.* (applying presumption even though the state law at issue was "a revenue raising measure, rather than a regulation of hospitals"). And in any event, the manner of regulation here more strongly warrants a presumption against preemption than the law at issue in *De Buono*. Whereas the hospital tax found eligible for a strong presumption in *De Buono* raised revenue for New York's general treasury, *see id.* at 809-10, APCDs promote better health care directly, by allowing evidence-based policymaking, increasing competition, and promoting cost transparency.

The court below also wrongly assumed that the States have not historically collected health care data when it concluded that APCD laws fall outside "the states' historic police power." Pet. App. 18 n.8. In fact, APCDs are an effort to achieve on a comprehensive scale the kind of health data collection that States have long pursued, dating back to the Colonial Era. In 1743, the Rhode Island colony created the first government-mandated disease registry, requiring the reporting of all instances of smallpox, yellow fever, and cholera. Bernard C.K. Choi, *The Past, Present, and Future of Public Health Surveillance*, 2012 Scientifica ID 875253, at 2.2. In 1850, a state legislator in Massachusetts proposed a regular census of the State's health data by age and sex; his bill became the template for laws creating health registries in the twentieth century. *Id.* For example, in 1935, Connecticut created the nation's first cancer registry, which contains a record of every tumor diagnosed in the State since that year. *See* Conn. Dep't of Pub. Health, *Connecticut Tumor Registry*. Forty-five States now have similar registries, half of them dating back to the 1960s and 1970s. *See* Nat'l Cancer Inst., *National and State Cancer Registries*.

In the past thirty years, forty-eight States have introduced requirements that hospitals report discharge data from inpatient hospitalizations,[14] and

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[14] *See, e.g.*, 10 N.Y.C.R.R. § 400.18 (previously § 405.30) (creating Statewide Planning and Research Cooperative System reporting of hospitalization data since 1979); N.H. Code Admin. R. ch. He-C 1500 (requiring reporting of hospital discharge data since 1986).

thirty states have extended those requirements to emergency room visits. *See* Denise Love et al., *All-Payer Claims Databases: State Initiatives to Improve Health-Care Transparency* 3 (The Commw. Fund Issue Brief Sept. 2010). These hospital discharge databases (HDDs) are an important precursor to APCDs, and establish that States indeed have a long-standing and historic practice of collecting health care data.

HDDs, however, have significant limitations as guides to state health care policy. In particular, HDDs lack the capacity of APCDs to reveal the true cost of health care. What a provider initially charges for a health care service upon a patient's discharge is often much higher than the rate negotiated by health care payers. APCDs, because they are based on data from *paid* claims, disclose the real-world prices paid for health care services. *See* Denise Love & Claudia Steiner, *Key State Health Care Databases for Improving Health Care Delivery* (Feb. 2011).

APCDs thus continue and improve a long-standing state practice of using health data collection to supervise public health. Moreover, as the United States has noted, there is no federal APCD, making States "uniquely positioned" to serve this function. Br. for the United States as *Amicus Curiae* on Cert. at 22.

II. The Presumption Against Preemption Is Not Overcome Here Because APCD Laws Do Not Implicate ERISA's Objectives or Interfere with Its Requirements.

ERISA manifests no congressional intent to preempt state laws collecting health care data, as is evident from "'the objectives of the ERISA statute'" and the "'nature of the effect of'" APCD laws on ERISA plans. *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (quoting *Dillingham*, 519 U.S. at 325). APCD laws require reporting of data about individual, paid medical claims. See *supra* Part I.A. They do not affect the benefits that plans must offer, require the reporting of data about plans' fiscal stability, or otherwise intrude on ERISA's regulation of benefit plans, sponsors, trustees, fiduciaries, and participants. They thus do not "implicate[] an area of core ERISA concern." *Id.*

APCD laws are instead "general health care regulation[s]," *Travelers*, 514 U.S. at 661, and are among the many "generally applicable laws regulating 'areas where ERISA has nothing to say,'" *Egelhoff*, 532 U.S. at 147-48 (quoting *Dillingham*, 519 U.S. at 330). In holding that ERISA preempts APCD statutes because both involve "reporting" in the broadest sense, the court below ignored the practical approach to ERISA preemption that this Court has followed for more than two decades, and interpreted 29 U.S.C. § 1144(a) with the "uncritical literalism" that the Court has rejected. *See Travelers*, 514 U.S. at 656.

A. ERISA Preempts Only State Laws That Implicate Its Core Functions or Conflict with Its Requirements.

Congress enacted ERISA for the benefit of working Americans, as a response to the twin problems of pension fund looting and pension fund underfunding. *See Dillingham*, 519 U.S. at 326-27 (ERISA was enacted to prevent "mismanagement of funds" or "failure to pay employees benefits from accumulated funds" (quotation marks omitted)).[15] The statute's express purpose is to ensure that employees actually receive the benefits they earn over the course of their working lives. 29 U.S.C. § 1001(a).

ERISA was never intended to shield employers from the "'myriad state laws' of general applicability that impose some burdens on the administration of ERISA plans" but do not impede employers from complying with ERISA's own requirements. *De Buono*, 520 U.S. at 815 (quoting *Travelers*, 514 U.S. at 668). To the extent that ERISA confers a benefit on employers by preempting certain state laws, *see* 29 U.S.C. § 1144(a) (superseding state laws that

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[15] *See also* Sen. Jacob K. Javits, Address at the Briefing Conference on Pension and Employee Benefits (Sept. 19, 1974) (stating that ERISA's purpose was "to safeguard workers against loss of their earned or anticipated benefits, which, over the years, had led to widespread frustration and bitterness"), *quoted in* Michael S. Gordon, *Overview: Why Was ERISA Enacted?*, Staff of Senate Special Comm. on Aging, 98th Cong., *The Employee Retirement Income Security Act of 1974: The First Decade* 25 (Comm. print 1984).

"relate to any employee benefit plan"), it does that to make compliance with ERISA itself feasible. For example, ERISA guarantees employers "'a set of standard procedures *to guide processing of claims and disbursement of benefits*,'" *Egelhoff*, 532 U.S. at 148 (emphasis added) (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987)), but does not contain any broader promise of general administrative uniformity. As one court of appeals has noted, an "effect on uniform plan administration would assuredly arise from the apprentice wage law in *Dillingham* and the state tax at issue in *De Buono*, but the Supreme Court found no ground for preemption in those cases." *Willmar Elec. Serv., Inc. v. Cooke*, 212 F.3d 533, 539 (10th Cir. 2000).

This Court "look[s] . . . to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive," rather than attempting to parse the meaning of the words "relate to" in § 1144(a). *See Travelers*, 514 U.S. at 656. This is because, "as many a curbstone philosopher has observed, everything is related to everything else." *Dillingham*, 519 U.S. at 335 (Scalia, J., joined by Ginsburg, J., concurring).

Since *Travelers*, this Court has invalidated only three state laws on the grounds that they improperly "relate to" ERISA plans within the meaning of § 1144(a). Two of those laws would have affected to whom plan benefits should be paid, and thus conflicted with ERISA's own rules for payment of benefits. *See Egelhoff*, 532 U.S. at 147-48 (state law automatically revoking spouse's interest in benefit plan upon divorce); *Boggs v. Boggs*, 520 U.S. 833, 844 (1997) (state law allowing nonparticipant spouse to convey an interest in plan via her will). The third law

would have required an employee's claim for benefits to be treated as timely even if the employee incorrectly gave notice of the claim to the employer instead of the insurer, thus changing the benefits that a plan must offer. *See UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 377-79 (1999). Over the same time period, this Court has rejected ERISA preemption challenges to state laws occupying fields that ERISA does not touch, even where those laws have had some effect on ERISA plans. *See, e.g., De Buono*, 520 U.S. at 816 (taxes on hospitals); *Dillingham*, 519 U.S. at 330 (prevailing wage and apprenticeship laws); *Travelers*, 514 U.S. at 662 (regulation of the actual cost charged for medical services).

As these cases demonstrate, the Court has "discern[ed] no solid basis for believing that Congress, when it designed ERISA, intended fundamentally to alter traditional preemption analysis."[16]

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[16] Courts and commentators frequently cite *Travelers* as the starting point for this Court's current approach to ERISA preemption because of its explicit instruction that courts should focus on ERISA's purposes in judging the scope of preemption. *See, e.g.*, John H. Langbein et al., *Pension and Employee Benefit Law* 842 (5th ed. 2010) (describing *Travelers* as a "sea change" in ERISA preemption). But as Justice Scalia pointed out in his *Dillingham* concurrence, Justice Ginsburg first announced the current standard in her *Harris Trust* majority opinion two years earlier. 519 U.S. at 336 (Scalia, J., joined by Ginsburg, J., concurring) (citing *Harris Trust*, 510 U.S. at 99). Clarity in the applicable legal framework is important to guide lower courts past potentially vexing questions, and the Court has previously chosen to "make a clean break" with statements in prior § 1144 opinions when appropriate to ensure analytic clarity. *See Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 341 (2003)

John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank, 510 U.S. 86, 99 (1993). *see also Dillingham*, 519 U.S. at 336 (Scalia, J., joined by Ginsburg, J., concurring) ("[I]t accurately describes [the Court's] current ERISA jurisprudence to say that [the Court] appl[ies] ordinary field pre-emption, and, of course, ordinary conflict preemption.").

In sum, ERISA preempts regulation of the relationships among the "core ERISA entities" whose interactions are already regulated by ERISA—namely, the "beneficiaries, participants, administrators, employers, trustees and other fiduciaries, and the plan itself." *Gerosa v. Savasta & Co.*, 329 F.3d 317, 324 (2d Cir. 2003). Every circuit that has considered the question agrees.[17] State laws that do

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[17] Nine circuits have resolved the proper scope of § 1144(a) by adopting a test assessing whether a state law interferes with ERISA's regulation of the relationship among the core ERISA entities. *See Carpenters Local Union No. 26 v. U.S. Fid. & Guar. Co.*, 215 F.3d 136, 141 (1st Cir. 2000); *Gerosa*, 329 F.3d at 324 (2d Cir.); *LeBlanc v. Cahill*, 153 F.3d 134, 147 (4th Cir. 1998); *Sommers Drug Stores Co. Emp. Profit Sharing Trust v. Corrigan Enters., Inc.*, 793 F.2d 1456, 1467-68 (5th Cir. 1986); *Self-Insurance Inst. of Am., Inc. v. Snyder*, 761 F.3d 631, 635-36 (6th Cir. 2014); *Wilson v. Zoellner*, 114 F.3d 713, 720-21 (8th Cir. 1997); *Paulsen v. CNF Inc.*, 559 F.3d 1061, 1082 (9th Cir. 2009); *Woodworker's Supply, Inc. v. Principal Mut. Life Ins. Co.*, 170 F.3d 985, 990 (10th Cir. 1999); *Morstein v. Nat'l Ins. Servs., Inc.*, 93 F.3d 715, 722-723 (11th Cir. 1996) (en banc). That test accurately and simply reflects congressional intent and reconciles all of this Court's rulings on preemption under § 1144(a). *See generally Gen. Am. Life Ins. Co. v. Castonguay*, 984 F.2d 1518, 1522 (9th Cir. 1993) (analyzing the law at length and concluding that preemption of a state law under ERISA requires a court to "look at whether it encroaches on the relationships regulated by ERISA").

not affect the relationships among these groups operate in a field separate from ERISA. Accordingly, they are not preempted unless they would necessarily alter how benefits are paid, or to whom. *See, e.g., Gerosa*, 329 F.3d at 324.

B. The Reporting Requirements of APCD Laws Are So Unrelated to the Reporting Requirements of ERISA That They Neither Intrude on ERISA's Field nor Conflict with It.

The reporting requirements in ERISA do not preempt the reporting requirements of state APCD laws because they are so utterly different in both character and purpose. As relevant here, ERISA requires reports from plan sponsors to plan participants and to the Secretary of Labor, for purposes of fiscal oversight.[18] State APCD laws, by comparison, require health payers to report data about paid medical claims for purposes of improving substantive health care policy. See *supra* Part I.A.

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[18] The Affordable Care Act amended Part 7 of ERISA's regulatory provisions to add certain reporting requirements with respect to minimum levels of quality care. *See* 29 U.S.C. § 1185d(a); 42 U.S.C. § 300gg-17(a). However, those requirements are not relevant here, because ERISA expressly states that nothing in Part 7 should be construed to expand ERISA's preemptive scope. *See* 29 U.S.C. § 1191(a)(2).

1. The field ERISA preempts is the reporting of data about plan finances to enable oversight of their fiscal stability, and that field is not implicated by APCD laws.

ERISA requires plan sponsors to report plan details and finances, *see* 29 U.S.C. §§ 1021-1030, so that plan participants and the Secretary of Labor can assess whether the plans are financially stable and responsibly managed, *see Fort Halifax*, 482 U.S. at 15. In particular, ERISA requires self-funded plans to file an annual report with the Secretary. *See* 29 U.S.C. § 1023. That report must disclose the plan's assets and liabilities; its receipts and disbursements; the identities of the plan's fiduciaries, trustees, and administrators; and statements from independent accountants and actuaries confirming that the plan has kept its books in accordance with accepted principles. *See id.* These reports enable participants, their designated beneficiaries, or the Secretary to bring a civil enforcement action when it appears a plan has fallen below ERISA's standards. *See id.* § 1132. Thus, supervision of the fiscal stability and ethical management of ERISA plans, and any enforcement proceedings arising from that supervision, are the "exclusive" provinces of federal law. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004). Elsewhere, separate from its reporting requirements, ERISA creates a nationwide set of rules for plan administrators to follow in deciding how plans are to be funded, *see* 29 U.S.C. § 1082, and to whom, when, and how benefits are to be paid, *see id.* §§ 1002(8), 1102(b)(4).

State APCD statutes collect different data for an entirely different purpose: the improvement of state

health care policy. As Vermont correctly points out, APCD laws do not even apply to "ERISA plans as *plans*." Pet. Br. 38. Instead, they require all health care *payers*—a group that happens to include self-funded health benefit plans—to report medical data to databases, usually run by state health departments. Indeed, Liberty Mutual expressly conceded below (*see* Pet. App. 38 (Straub, J., dissenting)) that there is no overlap between the data reported under ERISA and the data that APCD laws require. That concession should have resolved this case.

A state law's operation in an area completely separate from ERISA's objectives is a strong indication that such a law is *not* preempted. The court below lost sight of this principle when it concluded that because ERISA imposes certain reporting requirements, States may not require plans to report information unrelated to the fiscal stability and funding of plans. By defining "reporting" more broadly than the function it serves in ERISA's scheme, the court below failed to follow this Court's repeated instructions to "look to . . . the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Dillingham*, 519 U.S. at 325 (quotation marks omitted); *see also De Buono*, 520 U.S. at 813-14 (same); *Travelers*, 514 U.S. at 656 (same). Following those instructions forecloses any argument that "reporting" is a field that ERISA preempts: ERISA's objective is to make sure that the Secretary and plan participants have access to the information they need to scrutinize a plan's fiscal stability; the reporting of certain specific types of data is merely a means of attaining that objective. State laws that require reporting of categorically distinct data, as do APCD

laws, do not encroach on the federal role. Moreover, APCD laws do not regulate the relationships among ERISA's core entities; they would at most affect "merely the plan's bookkeeping obligations." *UNUM*, 526 U.S. at 378.

2. APCD laws do not conflict with ERISA even if they impose some economic burden on self-funded plans.

Under this Court's precedents, APCD laws do not conflict with ERISA simply because they seek "different and additional" data from the information sought by ERISA, Pet. App. 24 n.11, thereby imposing some cost or administrative burden on self-funded plans. As this Court has recognized, it would do "grave violence" to the presumption against preemption to "hold pre-empted a state law in an area of traditional state regulation based on so tenuous a relation" as financial cost. *Dillingham*, 519 U.S. at 334. Congress simply did not intend for ERISA to preempt "all laws with indirect economic effects on ERISA plans." *Travelers*, 514 U.S. at 664-65. Indeed, this Court has made clear that even a state *tax* that "increases the cost of providing benefits" to employees covered by a self-funded plan is not preempted when the tax applies generally to the health care industry. *See De Buono*, 520 U.S. at 811, 816. Similarly, in *Travelers*, this Court recognized that the hospital surcharges at issue would cost ERISA plans some profits, but it upheld them because that cost did not dictate any choices that the plans faced *as ERISA plans*. 514 U.S. at 659. APCD laws merely require the mandatory transmission of claims data already collected by a plan's TPA in the ordinary course of business, and

any costs the laws may impose are even more indirect than the state laws sustained by this Court in *De Buono* and *Travelers*.

Moreover, the record in this case contains no evidence that complying with Vermont's APCD requirements will result in any net cost or administrative burden. Nor is there any basis to conclude that Vermont's APCD law would have such "acute . . . economic effects" on self-funded plans as to force an alteration in the benefits they could provide, *see Travelers*, 514 U.S. at 668; Br. for the United States as *Amicus Curiae* on Cert. 12-13 (noting that "the record before the court of appeals" is insufficient to find more than an "incidental effect" on respondent). This Court's cases demand far more evidence of effect than Liberty Mutual's conclusory assertion that "all regulations have their costs." Br. for Liberty Mutual 28 (2d Cir. No. 12-4881, ECF No. 50).

Compliance with APCD laws may impose little to no administrative burden on health care payers. When a plan or third-party administrator transmits data about a claim to an APCD, it can generally do so using procedure and cost codes already widely used in health care billing. *See* Nat'l Ass'n of Health Data Orgs., *All-Payer Claims Databases*. These codes, which will usually be included with the required patient demographic data on the claim itself, provide most of the information APCDs require.

On the other hand, excluding data from self-funded plans will likely increase administrative costs for health care payers. Like many third party administrators, BCBSMA—Liberty Mutual's third party administrator—is also an issuer of traditional

commercial health insurance in its own right. There is no dispute that in that role BCBSMA must comply with state APCD laws, and it already provides APCD reports covering thousands of Vermonters, carving out only the 137 individuals Liberty Mutual has asked it to omit. *Compare* App. 204-05, *with* Pet. App. 50. Under Liberty Mutual's proposed regime, BCBSMA and other TPAs would be required to undertake the additional effort of sorting through their claims data to identify and exclude claims paid by self-funded plans, before they could transmit their reports to a state APCD.

For more than twenty years, this Court has rejected "uncritical literalism" in interpreting ERISA's preemption clause. *Dillingham*, 519 U.S. at 325 (quoting *Travelers*, 514 U.S. at 656); *see also De Buono*, 520 U.S. at 812-13 (criticizing Second Circuit for "failing to give proper weight to *Travelers*' rejection of a strictly literal reading of [29 U.S.C. § 1144(a)]"); *Self-Insurance Inst. of Am., Inc. v. Snyder*, 761 F.3d 631, 635-36 (6th Cir. 2014) (declining to follow the Second Circuit's "literal approach to preemption" in this case), *pet. for cert. filed*, No. 14-741 (U.S. Dec. 23, 2014). And there are sound reasons for its approach.

The revival of literalism in ERISA preemption analysis would threaten a broad array of state laws that have no connection to ERISA's functions or purposes, and that Congress never intended to preempt. For example, Michigan has imposed a one-percent tax on all paid claims in order to fund its Medicaid obligations, and has imposed on all insurers (including self-funded plans) the ministerial duties of recording and reporting the tax payments. *See Self-Insurance Inst.*, 761 F.3d at 633. Because the compu-

tation of taxes is "a function entirely divorced from plan administration," *id.* at 636, and falls within an area of traditional state authority, *see id.* at 635 (describing taxation as "an important 'attribute of state sovereignty'"), the Sixth Circuit correctly rejected a preemption challenge. Yet under the theory propounded by the court below, the Michigan law would be related to ERISA plans because it requires reporting in the broadest sense, at some unspecified cost to plans. That cannot be correct, for the only effect of Michigan's law is to "cut the plans' profits" in exactly the same manner as "the surcharges upheld in *Travelers* and *De Buono*," and "to create work independent of the core functions of ERISA." *Id.* at 636. Further, accepting the Second Circuit's broad theory about reporting obligations would have a dramatic effect: under that court's logic, "states would not be able to require ERISA-covered entities to submit any paperwork or preserve any records in any circumstances," and, "[a]s a result, ERISA would preempt any state laws requiring ERISA-covered entities to submit income-tax returns, property-tax returns, or employment records," *id.* at 638.

In sum, the effect of the lower court's approach to ERISA preemption in this case is to curtail States' authority to regulate not only here but also in many areas of traditional state interest, including health and safety, taxation, and licensing. See Pet. 32-33. Congress did not contemplate that outcome when enacting ERISA.

CONCLUSION

The judgment of the court of appeals should be reversed.

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No. 14-181

In The
Supreme Court of the United States

ALFRED GOBEILLE, in His Official Capacity as Chair of the Vermont Green Mountain Care Board,

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

BRIEF OF PROFESSOR EDWARD A. ZELINSKY AS *AMICUS CURIAE* IN SUPPORT OF NEITHER PARTY

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INTEREST OF THE *AMICUS CURIAE*

Edward A. Zelinsky is the Morris and Annie Trachman Professor of Law of the Benjamin N. Cardozo School of Law of Yeshiva University.[1] He teaches and writes in the area of employee benefits and ERISA law, including the law of ERISA preemption. His ERISA-related writing has previously been cited by this Court.[2] As a teacher and a scholar, he has an interest in the clarification and sound development of the law of ERISA preemption.

SUMMARY OF ARGUMENT

This case is an opportunity for the Court to correct the three fundamental problems of current preemption jurisprudence under the Employee

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[1] Professor Zelinsky wrote this *amicus* brief as one of several projects he completed on a summer research grant from the Cardozo Law School. The views expressed in this brief are his personal views. Neither the Cardozo Law School nor Yeshiva University expresses any opinion on the issues addressed in this brief. No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than the *amicus curiae* and Cardozo Law School made a monetary contribution to its preparation or submission. Both the petitioner and the respondent have, pursuant to Supreme Court Rule 37.3, submitted letters to the Clerk granting blanket consent for all *amicus curiae* briefs.

[2] *LaRue v. DeWolff, Boberg & Assocs.*, 552 U.S. 248, 255 (2008) (citing Edward A. Zelinsky, *The Defined Contribution Paradigm*, 114 YALE L. J. 451 (2004)).

Retirement Income Security Act of 1974 (ERISA). First, unlike the lower courts and commentators, the Supreme Court has yet to acknowledge the tension between the seminal ERISA preemption decision in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), and the subsequent decision in *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995). Second, per *Travelers*, the Court has read ERISA's preemption clause, ERISA § 514(a), 29 U.S.C. § 1144(a), as nothing more than a codification of traditional, deferential preemption standards. This reading of § 514(a) is textually unpersuasive and renders ERISA §§ 514(b)(2)(A) and 514(b)(4), 29 U.S.C. §§ 1144(b)(2)(A) and 1144(b)(4), redundant. Section 514(a) is better read as establishing a presumption for preemption.

Third, *Travelers* asserts that the presumption against ERISA preemption applies with particular force to state regulation of an area like health care "which historically has been a matter of local concern." This judge-made rule also runs afoul of §§ 514(b)(2)(A) and 514(b)(4) which specifically exempt from ERISA preemption state banking, securities, insurance and criminal laws, but no other state laws.

The Court should acknowledge the tension between *Shaw* and *Travelers*, should resolve that tension by declaring that ERISA § 514(a) establishes a presumption for preemption, and should read ERISA §§ 514(b)(2) and 514(b)(4) as they were written to identify the only areas of state law protected from

that presumption. This framework should then be used to determine whether ERISA preempts Vt. Stat. Ann. tit. 18, § 9410 and the regulations thereunder.

ARGUMENT

I. The Court should confront the tension between *Shaw* and *Travelers*.

The Court should acknowledge and confront the tension between *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), and *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).

Shaw construes ERISA as preempting expansively. Under *Shaw*'s capacious standard, ERISA § 514(a), 29 U.S.C. § 1144(a), preempts any state law which "has a connection with or reference to" an employee benefit plan. *Shaw*, 463 U.S. at 96-97. In contrast, *Travelers* defines ERISA preemption more restrictively. Under *Travelers*' narrower construction of § 514(a), ERISA does not preempt a state law merely because of "an indirect economic effect on choices made by insurance buyers, including ERISA plans." *Travelers*, 514 U.S. at 659.

The tension between *Shaw* and *Travelers* has been widely noted by the lower courts (including the court below) and by commentators. *See, e.g.*, *Liberty Mut. Ins. Co. v. Donegan*, 746 F.3d 497, 506 (2d Cir. 2014) (*Travelers* "marked something of a pivot in

ERISA preemption."); *Golden Gate Rest. Ass'n v. City & County of San Francisco*, 546 F.3d 639, 654 (9th Cir. 2008) ("We read *Travelers* as narrowing the Court's interpretation of the scope of § 514(a)."); Edward A. Zelinsky, Gobeille v. Liberty Mutual: *An Opportunity to Correct the Problems of ERISA Preemption*, 100 CORNELL L.REV. ONLINE ___ (2015) (forthcoming), available on SSRN at papers.ssrn.com/sol3/papers.cfm?abstract_id=2595589 (hereinafter, Zelinsky, Gobeille); Edward A. Zelinsky, Travelers, *Reasoned Textualism and The New Jurisprudence of ERISA Preemption*, 21 CARDOZO L. REV. 807, 827 (1999) (hereinafter, Zelinsky, Travelers); Lawrence A. Frolik & Kathryn L. Moore, LAW OF EMPLOYEE PENSION AND WELFARE BENEFITS 209-210 (3rd ed. 2012); John H. Langbein, et al., PENSION AND EMPLOYEE BENEFIT LAW 767 (6th ed. 2015).

The split in the Second Circuit panel below reflects the well-recognized tension between *Shaw* and *Travelers*. The expansive construction of ERISA § 514(a) advanced by *Shaw* buttresses the conclusion of the Second Circuit majority that ERISA preempts the Vermont law and regulation at issue in this case. In contrast, *Travelers'* more restrictive approach to ERISA preemption sustains the dissent below against such preemption.

The tensions reflected in Chief Judge Jacobs' opinion and Senior Judge Straub's dissent will recur until this Court confronts and resolves the tension between the disparate approaches to § 514(a) advanced in *Shaw* and *Travelers*.

II. ERISA § 514(a) should be construed as establishing a presumption for preemption.

Central to the tension between *Shaw* and *Travelers* is *Travelers'* reading of ERISA § 514(a) as a codification of traditional, deferential preemption standards. This reading of § 514(a) is unpersuasive and renders redundant ERISA §§ 514(b)(2)(A) and 514(b)(4). ERISA Section 514(a) is better read as establishing a presumption for preemption.

The problems with construing ERISA § 514(a) as embodying traditional preemption standards start with the text of § 514(a) itself. While the conventional judicial approach is a presumption against preemption, § 514(a) says nothing of the sort. Section 514(a) broadly states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any" employee benefit plan. This expansive statutory language says nothing about a presumption against preemption or about preserving state law.

The capacious language of § 514(a) contrasts with other federal preemption statutes which carefully preserve the prerogatives of the states. Zelinsky, Gobeille, *supra* (contrasting ERISA § 514 with other federal preemption clauses). As a textual matter, it is not persuasive to read the sweeping language of § 514(a) as creating a presumption for the preservation of state law. Congress knows how to write a statute preserving state law when it wants one.

ERISA Section 514(a) is not such a statute. Zelinsky, Gobeille, *supra*.

ERISA §§ 514(b)(2)(A) and 514(b)(4) compound the textual difficulty of reading § 514(a) as a presumption against preemption. Sections 514(b)(2)(A) and 514(b)(4) protect state insurance, banking, securities and criminal laws against the scope of § 514(a). If § 514(a) simply embodies the traditional presumption against preemption, from what are §§ 514(b)(2)(A) and 514(b)(4) protecting? Construing § 514(a) as creating the traditional presumption against preemption renders §§ 514(b)(2)(A) and 514(b)(4) redundant since, under that construction, there is nothing from which state banking, securities, insurance and criminal laws need relief.

As the Court observed in *Travelers*, an unqualified statutory phrase like "relate to" can be "taken to extend to the furthest stretch of its indeterminacy." *Travelers*, 514 U.S. at 656. However, there is an alternative reading of ERISA § 514(a) which gives content to that provision without reaching such indeterminacy: construe § 514(a) as a presumption for preemption. Zelinsky, Travelers, *supra* at 839.

Such an interpretation of ERISA § 514(a) also gives substance to the exceptions created in §§ 514(b)(2)(A) and 514(b)(4). If § 514(a) is understood as replacing the traditional presumption against preemption with a statutorily-mandated presumption for such preemption, §§ 514(b)(2)(A) and 514(b)(4) then relieve from this presumption for preemption

state insurance, banking, securities and criminal laws. That relief restores these four categories of state law back to the traditional presumption against preemption.

There is, in short, a way to respect the text of ERISA § 514(a) without yielding to either the problematic *Shaw*-based alternative of preemption without limit or the equally problematic approach under *Travelers* which deprives § 514(a) of any meaningful content: construe § 514(a) as establishing a presumption for preemption, a presumption from which state banking, securities, insurance and criminal laws are saved by §§ 514(b)(2)(A) and 514(b)(4). *See* Zelinsky, Travelers, *supra* at 832.

III. ERISA §§ 514(b)(2)(A) and 514(b)(4) exclusively define "matter[s] of local concern."

A central theme of *Travelers* is that ERISA preemption is inappropriate for state regulation of health care "which historically has been a matter of local concern." *Travelers*, 514 U.S. at 661. However, ERISA §§ 514(b)(2)(A) and 514(b)(4) outline the areas of state law to be protected from § 514(a)'s preemptive effect. Health care is not among these.

Postulating a judicially-determined sphere for historic matters of local concern renders §§ 514(b)(2)(A) and 514(b)(4) redundant. Nothing in these provisions indicates that the statutory list – state banking, securities, insurance and criminal laws – is merely

illustrative and may be augmented by other, judicially-recognized areas to be immunized from § 514(a)'s preemptive effect.

There may be a compelling case as a matter of policy for Congress to add health care to the areas protected from ERISA § 514(a)'s preemptive effect. There is, however, no warrant under § 514 as it now reads for the courts to reach that result in the teeth of the statute. Zelinsky, Gobeille, *supra*.

Under this framework, ERISA § 514(a) creates a presumption that the Vermont statute at issue in this case, Vt. Stat. Ann. tit. 18, § 9410, is preempted since that statute is not a state banking, securities, insurance or criminal law. The next and controlling inquiry is then whether Vermont can overcome that presumption.

CONCLUSION

The Court should acknowledge the tension between *Shaw* and *Travelers*, should resolve that tension by declaring that ERISA § 514(a) establishes a presumption for preemption, and should read ERISA §§ 514(b)(2)(A) and 514(b)(4) as they were written to identify the only areas of state law protected from that presumption. This framework should then be

used to determine whether ERISA preempts the Vermont statute and the regulations thereunder.

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